EXHIBIT E

STATE OF ALABAMA)

GENEVA COUNTY)

CERTIFICATION OF RECORDS

I, Lea Morris, of the office of the Wiregrass Medical Center, do hereby certify that the documents annexed are a true copy from the original records of Jowel S. Nunn, SSN: 422-84-7896, DOB 01/08/77, which are authorized by law to be and are, in fact, made and maintained in the regular and ordinary course of business and on file at the office of the Wiregrass Medical Center and in its legal custody.

Executed this 1st day of August, 2006.

Lea Morris

Sworn to and subscribed before me this 1st day of August, 2006.

(SEAL)

Faye Owen
Notary Public
My Commission Expires:

MY COMMISSION EXPIRES
AUGUST 27, 2008

AO88 (Rev. 1/94) Subpoena in a Civil Case

Issued by the

UNITED STATES DISTRICT COURT

MIDDLE DISTRICT OF ALABAMA

JOWEL S. NUNN,

V.

GREG WARD, et al.

SUBPOENA IN A CIVIL CASE

Case Number:[1] 1:06-CV-452-MEF

TO: Wiregrass Medical Center
1200 W. Maple Ave.
Geneva, AL 36340

☐ YOU ARE COMMANDED to appear in the United States District court at the place, date, and time specified below testify in the above case.

PLACE OF TESTIMONY	COURTROOM
	DATE AND TIME

☐ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify at the taking of a deposition in the above case.

PLACE OF DEPOSITION	DATE AND TIME

☑ YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects at the place, date, and time specified below (list documents or objects):

Please see attached Exhibit A and Exhibit B

PLACE	DATE AND TIME
*you may mail the documents to the address below by the specified date.	5:00 p.m. 07/21/06

☐ YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below.

PREMISES	DATE AND TIME

Any organization not a party to this suit that is subpoenaed for the taking of a deposition shall designate one or more officers, directors, or managing agents, or other persons who consent to testify on its behalf, and may set forth, for each person designated, the matters on which the person will testify. Federal Rules of Civil Procedure, 30(b)(6).

ISSUING OFFICER'S SIGNATURE AND TITLE (INDICATE IF ATTORNEY FOR PLAINTIFF OR DEFENDANT)	DATE
Daniel Fordham Attorney For Defendants	7/7/2006

ISSUING OFFICER'S NAME, ADDRESS AND PHONE NUMBER

Daniel D. Fordham, Webb & Eley, P.C.
P.O. Box 240909, Montgomery, AL 36124-0240909 (334) 262-1850

(See Rule 45, Federal Rules of Civil Procedure, Parts C & D on next page)

[1] If action is pending in district other than district of issuance, state district under case number.

EXHIBIT A

ANY AND ALL CHARTS AND MEDICAL RECORDS, INCLUDING PRESCRIPTIONS, DOCTORS' NOTES, NURSES' NOTES, OPERATIVE NOTES, DISCHARGE SUMMARIES, CONSULTING PHYSICIANS' CORRESPONDENCE, CONSULTATION REPORTS, OFFICE NOTES OR MEMORANDA, HOSPITAL RECORDS, MEDICAL BILLS, REPORTS TO INSURANCE COMPANIES, X-RAY REPORTS OR OTHER DIAGNOSTIC REPORTS, CORRESPONDENCE TO OR FROM ATTORNEYS OR OTHER PHYSICIANS, OR ANY OTHER WRITTEN MATERIAL CONTAINED IN YOUR FILE OR IN YOUR POSSESSION REGARDING THE CARE AND TREATMENT OF JOWEL S. NUNN, SSN: 422-84-7896, DOB: 01/08/1977.

EXHIBIT B

HIPPA PRIVACY RULES' ASSURANCES

In accordance with the Federal Privacy Rules issued pursuant to the Health Insurance Portability and Accountability Act, ("HIPAA Privacy Rules"), we are providing you with the following satisfactory assurances:

a. We have made a good faith attempt to provide the Patient, via the United States Mail, with a copy of this Civil Subpoena.

b. The Civil Subpoena includes sufficient information about the litigation proceeding in which the medical and/or billing information is requested to permit the Patient to raise an objection.

Accordingly, following service of the Civil Subpoena, you may disclose the requested information in compliance with the HIPAA Privacy Rules.

In the event you cannot locate records concerning the Patient, please provide written notification to the requesting counsel. If you have any questions or concerns, please call the attorney for the Defendants, by contacting Daniel D. Fordham at (334) 262-1850.

WIREGRASS HOSPITAL 1200 W MAPLE AVE GENEVA AL 36340

EMERGENCY ROOM • OUTPATIENT RECORI

ATIENT NUMBER	TYPE	PATIENT NAME	AGE	BIRTHDATE	SEX	M/S	DATE OF SERVICE	TIME	CLERK INIT.
350235	3	NUNN JOWEL	21	1/08/1977	M	SB	5/29/98	11:58	GMR

DDRESS - LINE 1	ADDRESS - LINE 2	CITY	STATE	ZIP CODE	TELEPHONE
202 S BROAD		SAMSON	AL	36477	334-898-2433

ATIENT SSAN	NOTIFY IN CASE OF EMERGENCY - NAME	RELATIONSHIP	ADDRESS	TELEPHONE
422847896	NUNN LINDA	MOTHER		334-898-9198

SURANCE COMPANY	CONTRACT OR GROUP NUMBER	DATE	PLACE	ACCIDENT
		TIME	EVENT	

JARANTOR NAME	GUARANTOR ADDRESS	CITY	STATE	ZIP CODE	GUAR. TELEPHONE	GUARANTOR
DISTRICT ATTORNEY		GENEVA	AL	36340	898-9198	

JARANTOR EMPLOYER	GUARANTOR OCCUPATION	GUAR. EMPLOYER ADDRESS	GUAR. EMPL. TELEPHONE

REV. SERVICE	PREV. SERV. DATE	IF MINOR - PARENT NAME	MED. REC #	FAMILY PHYSICIAN
325993	5/30/97		422847896	MILLER J C/MILLER J C

CHARGES	X-RAY	LAB	RESP. TH.	PHY. TH.	EKG	I.V.	DRUGS	SUPPLIES	OTHER	M.D.	E.R. RM	TOTAL DUE

AUTHORIZATION FOR TREATMENT, GUARANTEE OF PAYMENT, ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned has been informed of the emergency treatment considered necessary for the above named patient, and that treatment and procedures will be performed by physicians, members of house staff and employees of the hospital. Authorization is hereby granted for such treatment and procedures. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained.
2. The undersigned agrees to pay for services rendered by Hospital upon release of patient.
3. I/we hereby assign any hospital benefits, sick benefits, injury benefits due to a liability of a Third party, payable by any party, for the above patient, to Hospital unless I pay the account in full upon release of patient.
4. I/we hereby authorize the "Administrator of Hospital" to furnish from its records any information requested by the before mentioned insurance companies in connection with the above assignment. I do hereby appoint the "Controller" of Hospital as my lawful attorney to endorse for me any checks made payable to me for benefits or claims collected under the above assignment and to apply any credit balance to any other account I may owe said hospital.

DATE TIME SIGNED PATIENT SIGNED GUARANTOR

CHIEF COMPLAINT (If Accident State How, When, and Where)
ORDER OF DA/EVIDENCE

TEMP	PULSE	RESP.	B/P	ALLERGIES	MEDICATIONS - HOME	E.R. PHYSICIAN	TET. TOX.

NURSES NOTES:

NURSES'S SIGNATURE (RN OR LPN)

LAB DATA (Including X-Rays, EKGs, etc.)

PHYSICIAN'S REPORT:

DIAGNOSIS:

TREATMENT:

CONDITION ON DISC	IMP	STABLE	EXPIRED

INSTRUCTIONS TO PATIENT:

FOLLOW-UP WITH M.D.

M.D.

PATIENT'S SIGNATURE ON DISCHARGE DATE - TIME OF DISC PHYSICIAN'S SIGNATURE

NUNN JOWEL
350235 MILLER J C MD E.R.
DOB-01/08/77 21 MALE
05/29/98
ER/ROOM
P PRIVATE PAY

ADDRESSOGRAPH

WIREGRASS HOSPITAL
GENEVA, AL 36340
ER MEDICAL RECORD

( ) EMERGENT ( ) URGENT ( ) NON-EMERGENT

TRIAGE NOTES: In to have male evidence collection kit.

TIME 1215
TEMP 98.1
PULSE 80
RESP 20

ALLERGIES Fresh TET ___ WT ___ B.P. 134-92

PRESENT MEDICATION ~~[illegible]~~ Tylenol PRN LMP ___ SaO2 ___

NURSE SIGNATURE Emily [illegible] RN

PHYSICIAN'S HISTORY AND PHYSICAL: CC

HPI Poss Rape participant

ROS

PMH

PSH

SOCIAL

FAM Hx

ALLERGIES

MEDS

PE/VS

HEENT

CHEST/LUNGS

HEART/CV

ABD//RECTAL

GU/GYN Hair combing, smear, pubic hair

EXT/SKIN [illegible] lab / kit

NEURO

DX Poss Rape involvement

PHYSICIAN'S ORDERS: CBC( ) CHEM (7)(24)

EKG( ) ABG( ) PT/PTT( ) AMYLASE( )

UA(ROUT)/(CATH) CT( )

CXR( ) F&E( ) US( )

CM( ) O2( ) FOLEY( ) IV: OTHER:

MEDICATION	INI

DISPOSITION: HOME( ) DR. OFFICE( ) SURGERY( ) EXPIRED( ) ADMIT RM#/ICU ___ AMA/L WBS( ) DATE/TIME 1430 5-29-98

TRANSFER TO ___ C/O DR ___ VIA ___

CONDITION AT DISCHARGE/TRANSFER: IMPROVED( ) STABLE( ) DETERIORATED( )

INSTRUCTIONS TO PT:

PHYSICIAN'S SIGNATURE: [illegible signature] **FAMILY DR.** None

WIREGRASS HOSPITAL

GENEVA, AL 36340

NUNN JOWEL E.R.
350235 MILLER J C MD
DOB-01/08/77 21 MALE
05/29/98

Addressograph

NURSING ASSESSMENT SHEET

DATE: 5-29-98 TIME: 1215

MODE OF ARRIVAL: ER/ROOM ( )AMBULATORY ( )WHEEL CHAIR ( )STRETCHER ( )AMBULANCE ( )ARMS ALLERGIES: Fish

ACCOMPANIED BY: ( )SELF ( )FAMILY/FRIENDS (X)POLICE ( )OTHER FAMILY DR.: none

TREATMENT PTA: ( )C COLLAR ( )SPINE BOARD ( )CID

AIRWAY: ( )ORAL ( )ET TUBE O2:____( )NC ( )MASK

DRESSING:

IV FLUIDS:

OTHER: None

TIME & INI		TIME & INI	
EKG		BREATHING TX	
MONITOR		NG TUBE	
O2		DRESSING	
ABG		FOLEY	
X-RAY		OTHER	

DR. CALLED

DR ARRIVED

NOTIFIED: ( )POLICE

( ) OTHER:

WHOM

TIME

RESPIRATORY: (✓)NORMAL ( )SHALLOW ( )DEEP

( )RETRACTIONS ( )LABORED ( )RAPID ( )SLOW

BREATH SOUNDS: (✓)CLEAR ( )RALES ( )WHEEZES

COUGH: ( )NON-PRODUCTIVE ( )PRODUCTIVE

CIRCULATION: SKIN (✓)WARM (✓)DRY ( )COLD

( )DIAPHORETIC ( )HOT ( )CLAMMY

COLOR: (✓)NORMAL ( )DUSKY ( )FLUSHED ( )PALE

( )CYANOTIC ( )JAUNDICED

MENTAL STATUS: (✓)ALERT (✓)ORIENTED

( )DISORIENTED RESPONDS TO: (VOICE) (PAIN)

( )LETHARGIC ( )UNRESPONSIVE

PUPILS: (EQUAL)/(UNEQUAL) FIXED:(PINPOINT)/(DILATED)

SIZE: <INSERT SIZE CHART HERE>

VISUAL ACUITY: OD:____/20 OS:____/20

ABDOMEN: BOWEL SOUNDS: (PRESENT) (ABSENT)

( )DISTENDED ( )TENDER ( )RIGID ( )SOFT

EXTREMETIES: (✓)WNL ( )EDEMA ( )COOL ( )WARM

ROM: Y / N DEFORMITY: Y / N SENSORY: Y / N

CAPILLARY: <3 sec PULSE:

GU/GYN: ( )DYSURIA ( )FREQUENCY ( )HEMATURIA

( )VAGINAL BLEEDING ( )DISCHARGE: VAG / URETHRA

G____P____A Denies

LACERATION: BLEEDING: Y / N / SIZE:

LOCATION: N/A

EMOTIONAL: AFFECT: WNL / FLAT (✓)COOPERATIVE

EYE CONTACT: Y / N ( )AGITATED ( )HOSTILE ( )ANXIOUS

( )COMBATIVE

NURSE: Emily Lotter RN EL

PATIENT VALUABLES GIVEN TO____TIME____( )HOSP SAFE

TIME	MEDICATION	ROUTE	SITE	INI	RESPONSE

TIME	TYPE IV	RATE	SIZE	SITE	INI

NURSES NOTES: 1230 Evidence collected for sexual assault per protocol. Evidence secured & given to officer Blackman of Samson PD. MG

NURSES SIGNATURE:	TITLE	INI

ED-OP
HOME INSTRUCTION SHEET

WIREGRASS HOSPITAL
1200 W. MAPLE AVE.
GENEVA, AL 36340
205-684-3655

1. MEDICAL RECORD NO.	2. BILLING NO.	3. A/R NO.

VISIT INFORMATION

4. CLASS	5. DATE	6. TIME	7. SRC	8. TYPE	9. SAD
	E.R.				

NUNN JOWEL
350235 MILLER J C MD

10. PATIENTS LEGAL NAME (L,F,MI)	11. SEX	12. RACE	13. BIRTH DATE	14. AGE	15. HEIGHT	16. WEIGHT	17. SS	18. MS	19.
			DOB-01/08/77	21	MALE				
			05/29/98						

20. RP	21. NOTIFY IN EMERGENCY	22. HOME TELE	23. WORK TELE	24. HOW PATIENT ARRIVED
		ER/ROOM		

25. C OMPLAINT 26	OUTPATIENT SURGERY INFORMATION				
	27. PROC CD	28. PROCEDURE	29. LOC	30. TIME	31. ANES
	P	PRIVATE PAY			

32. PHYSICIAN CALLED	33. ATTENDING PHYSICIAN	34. FAMILY PHYSICIAN

SPRAIN, FRACTURE, & SEVERE BRUISES

- ☐ Elevate the injured part above level of heart to lessen swelling. If pillows flatten, use chair cushions with pillows or blanket for comfort
- ☐ Ice packs also help prevent swelling, especially during the first 48 hours.
- ☐ Place ice in plastic or rubber bag, cloth covering; after 48 hours, use heat.
- ☐ If you have an elastic bandage, rewrap it if too tight or loose. Remove at bedtime and replace in A.M.
- ☐ If you have a cast, keep it perfectly dry at all times.
- ☐ Wiggle toes or fingers to help prevent swelling in the cast—this should be done often if it does not cause pain.
- ☐ If the part swells anyway, or gets cold, blue or numb or pain increases markedly, have it checked promptly
- ☐ Use crutches.

BACK AND NECK INJURY INSTRUCTIONS

- ☐ USE HEAT OR COLD ON THE INJURED AREA—whichever seems to help the most. Be careful not to burn yourself
- ☐ Rest as much as possible until you are improved
- ☐ Avoid positions and movement that make the pain worse.
- ☐ Relax emotionally—if you are tense the problem will only be worse.
- ☐ Gentle but firm massage will increase circulation in sore muscles and helps to clear the soreness
- ☐ Wear special collar when out of bed

HEAD INJURY INSTRUCTIONS

Persons who receive blows to the head may have injuries that cannot always be seen by X-ray or examination soon after accident. For the next 24 hours it is important that these instructions be followed

- ☐ Awaken the patient every two hours, even at night, to be sure he knows where he is and is not confused.
- ☐ Check eyes to see that both pupils are of equal size.
- ☐ Prevent the taking of sleeping pills, tranquilizers or alcohol
- ☐ Restrict excessive work or play.

Call your family doctor or local hospital immediately if the patient:

- ☐ Develops a severe headache
- ☐ Vomits more than twice within a short time.
- ☐ Is confused, faints or is hard to awaken.
- ☐ Has a pupil of one eye larger than the other
- ☐ Complains of double vision
- ☐ Shows abnormal behavior such as staggering or walking into things.

X-RAY INSTRUCTIONS

Your X-rays have been read by the attending physician in the Emergency Dept. For your added protection, your X-rays will be reread the next morning by Radiology Dept If any abnormalities are found that have not been called to your attention, you and your doctor will be called immediately. (Please be certain that the Emergency Dept has a phone number where you can be reached.) Sometimes fractures or abnormalities may not show up on X-rays for several days. If your symptoms continue or get worse, call your doctor More X-rays may need to be taken If you are referred to another physician, come by the hospital and pick up your X-ray and take them with you to the doctor's office. Please call ahead to X-ray Dept.

WOUND CARE (Cuts, Abrasions, Burns, Stitches)

- ☐ Keep the dressings clean and dry
- ☐ Elevate the wound to help relieve soreness and help speed wound healing
- ☐ Despite the greatest care, any wound can be infected. If your wound becomes red, swollen, shows pus or red streaks, or feels more sore instead of less sore as days go by, you must report to your doctor right away
- ☐ Dressing should be changed in _____ days
- ☐ Treatment rendered _____
- ☐ Tetanus Toxiod given _____ 250 units of tetanus immune globulin was given. To complete your immunization, you must receive two additional doses of toxoid 4-6 weeks apart. Call your physician for the next dose.
- ☐ Warm soaks to area 4 times daily, 20-40 minutes each time
- ☐ Continuous warm compresses.

VOMITING & DIARRHEA

- ☐ Do not feed anything for 4 hours
- ☐ After 4 hours, if there is no vomiting and/or diarrhea, offer 2 tablespoons (1 ounce) of any of the following clear liquids Coke, Gingerale, 7-up, weak tea, Gatorade or Jello water If patient is hungry you may add 1 teaspoon of sugar to each ounce of liquid.
- ☐ UNDER NO CIRCUMSTANCES USE MILK OR MILK PRODUCTS.
- ☐ The 2 tablespoons of liquid may be offered every hour If after 4 hours no vomiting has occurred, the amount may be slowly increased
- ☐ Using no more than ½ glass (4 ounces) of liquid at a time, continue this treatment for 24 hours.
- ☐ Contact your doctor's office for further instructions after 24 hours

GENERAL INSTRUCTIONS

- ☐ Stay in bed/may go to bathroom.
- ☐ Use vaporizer.
- ☐ Drink large amounts of liquids.
- ☐ Take ____ aspirin every 4 hours.
- ☐ Avoid any use of injured part.
- ☐ Allow only limited use of the part.
- ☐ You need not necessarily limit activity.
- ☐ Fill Prescriptions given to you from Emergency Dept. and take as directed.
- ☐ No driving or any activity requiring mental alertness after receiving medication.

FEVER OVER 102

- ☐ Sponge with lukewarm water in the tub.
- ☐ If temperature increases or persists for 24 hours, see your family doctor

EYE INJURY

- ☐ Any eye injury is potentially hazardous.
- ☐ Any increasingly severe discomfort, redness or sudden impairment of vision should be reported immediately to your physician or eye specialist below.
- ☐ Do not drive with eye patch.

ANIMAL OBSERVATION

Instructions for observation of any animal that may have bitten a human if that animal is available for observation.

- ☐ Have animal taken to Veterinarian for observation.
- ☐ If the owner should refuse to take the animal to the Veterinarian, notify the County Health Officer of the situation.

ADDITIONAL INSTRUCTIONS _____

I hereby acknowledge receipt of all the instructions indicated above. I understand that I have received EMERGENCY treatment only and that I may be released before all my medical problems are known or treated. I will arrange for follow-up care as indicated above. I understand that if my conditions worsen or new symptoms appear, I should contact my Doctor immediately.

PATIENT'S SIGNATURE	NURSE'S SIGNATURE	PHYSICIAN'S SIGNATURE

SCHOOL AND WORK EXCUSE · *PATIENT NAME* · DATE

- ☐ No work for _____ days
- ☐ Light work for _____ days
- ☐ May return to work on _____
- ☐ No school for _____ days
- ☐ No Physical Education for _____ days
- ☐ May return to school on _____

Wiregrass Hospital PHYSICIAN'S SIGNATURE

WIREGRASS MEDICAL CENTER 1200 W MAPLE AVE GENEVA AL 36340

EMERGENCY ROOM • OUTPATIENT RECORD

PATIENT NUMBER	TYPE	PATIENT NAME	AGE	BIRTHDATE	SEX	M/S	DATE OF SERVICE	TIME	CLERK INIT.
360064	3	NUNN JOWEL	21	1/08/1977	M	SB	10/31/98	7:51	LHS

ADDRESS - LINE 1	ADDRESS - LINE 2	CITY	STATE	ZIP CODE	TELEPHONE
202 S BROAD		SAMSON	AL	36477	334-898-2433

PATIENT SSAN	NOTIFY IN CASE OF EMERGENCY - NAME	RELATIONSHIP	ADDRESS	TELEPHONE
422847896	NUNN LINDA	MOTHER		334-898-9198

INSURANCE COMPANY	CONTRACT OR GROUP NUMBER	DATE / TIME	PLACE / EVENT

ACCIDENT

GUARANTOR NAME	GUARANTOR ADDRESS	CITY	STATE	ZIP CODE	GUAR. TELEPHONE
NUNN JOWEL	202 S BROAD	SAMSON	AL	36477	898-2433

GUARANTOR EMPLOYER	GUARANTOR OCCUPATION	GUAR. EMPLOYER ADDRESS	GUAR. EMPL. TELEPHONE
BROOKS PEANUT CO	LABORER		

GUARANTOR

PREV. SERV.	PREV. SERV. DATE	IF MINOR - PARENT NAME	MED. REC #	FAMILY PHYSICIAN
350235	5/29/98		422847896	HORNSBY K /SIMMONS J

CHARGES	X-RAY	LAB	RESP. TH.	PHY. TH.	EKG	I.V.	DRUGS	SUPPLIES	OTHER	M.D.	E.R. RM	TOTAL DUE

AUTHORIZATION FOR TREATMENT, GUARANTEE OF PAYMENT, ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned has been informed of the emergency treatment considered necessary for the above named patient, and that treatment and procedures will be performed by physicians, members of house staff and employees of the hospital. Authorization is hereby granted for such treatment and procedures. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained.
2. The undersigned agrees to pay for services rendered by Hospital upon release of patient.
3. I/we hereby assign any hospital benefits, sick benefits, injury benefits due to a liability of a Third party, payable by any party, for the above patient, to Hospital unless I pay the account in full upon release of patient.
4. I/we hereby authorize the "Administrator of Hospital" to furnish from its records any information requested by the before mentioned insurance companies in connection with the above assignment. I do hereby appoint the "Controller" of Hospital as my lawful attorney to endorse for me any checks made payable to me for benefits or claims collected under the above assignment and to apply any credit balance to any other account I may owe said hospital.

DATE TIME SIGNED PATIENT SIGNED GUARANTOR

CHIEF COMPLAINT (If Accident State How, When, and Where)
DISCHARGE FROM PENIS

TEMP	PULSE	RESP.	B/P	ALLERGIES	MEDICATIONS - HOME	E.R. PHYSICIAN	TET. TOX.

NURSES NOTES:

NURSES'S SIGNATURE (RN OR LPN)

LAB DATA (Including X-Rays, EKGs, etc.)

PHYSICIAN'S REPORT:

DIAGNOSIS:

TREATMENT:

CONDITION ON DISC: IMP | STABLE | EXPIRED

INSTRUCTIONS TO PATIENT:

FOLLOW-UP WITH M.D.

M.D.

PATIENT'S SIGNATURE ON DISCHARGE DATE - TIME OF DISC PHYSICIAN'S SIGNATURE

Wiregrass Hospital
1200 W. Maple Avenue
Geneva, Alabama 36340

360064

CONDITIONS FOR TREATMENT

1. **MEDICAL AND SURGICAL CONSENT FOR TREATMENT:** The undersigned hereby authorizes WIREGRASS HOSPITAL to furnish the necessary treatment, surgical procedures, anesthesia, x-ray examinations or treatments, drugs and supplies as may be ordered or requested by the attending physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery or examinations in the hospital. The undersigned recognizes that all physicians furnishing services to the patient may be independent contractors and are not employees or agents of the Hospital.

2. **RELEASE OF INFORMATION:** The undersigned hereby authorizes WIREGRASS HOSPITAL to release to any insurers, their representatives or other third parties confidential information (including copies of records) relative to this hospitalization. This authorization includes, but is not limited, to the release of information relating to drug, alcohol and or psychiatric treatment as specified in Federal Regulation 42, CFR part 2. I further authorize any physician or institution that attended the patient previously to furnish medical records or information which may be requested by the Hospital or attending physicians.

3. **RELEASE FROM LIABILITY FOR VALUABLES:** I have been made aware that WIREGRASS HOSPITAL provides facilities for the safe keeping of my valuables and therefore, I release the Hospital from any responsibility due to loss or damage of my clothing, money, jewelry, or other items of value that I might keep at my bedside, or that may be brought to me by my friends and relatives.

4. **GUARANTOR AGREEMENT:** The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.

5. **ASSIGNMENT OF INSURANCE BENEFITS:** In the event the undersigned and/or patient is entitled to Hospital benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to WIREGRASS HOSPITAL for application to the patient's bill. It is agreed that the Hospital may receipt for any such payment and such payment will discharge the said insurance company of all obligations under the policy to the extent of such payment. The undersigned and/or patient agrees to be responsible for charges not paid by this assignment.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ OR HAD THE FOREGOING INFORMATION EXPLAINED, HAS RECEIVED A COPY, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Date 10-31 19 98 X Jewel S. Nunn
Patient

Witness Lee Rodgers

Patient's Agent or Representative

Relationship to Patient

ASSIGNMENT OF MEDICARE BENEFITS:
PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST

"I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for Part A deductible for each spell of illness, the Part B deductible for each year, the remaining 20% of reasonable charges and any personal charges incurred."

Date Signature Relationship to Patient

ACKNOWLEDGEMENT OF MEDICARE

I hereby declare I am a participant in the Medicare Program and I am not enrolled in a health maintenance organization, (H.M.O.), or any other pre-paid group practice. I understand that if it is found that I am a participant in any of the above mentioned practices, I will be considered a self-pay patient required to pay in full immediately.

Date Signature Relationship to Patient

PRINT DATE: 11/03/98 Wiregrass Hospital PAGE 1
Louis E. Seibert, M. D. 01D0304961
Medical Director CLIA Number
TIME: 13:00 LABORATORY --- CUMULATIVE REPORT H5LACUMV

NAME.: NUNN JOWEL SEX.....: M PHY..: HORNSBY KEVIN
ACCT#: 360064 AGE.....: 21 Y ADMIT: 10/31/98
ROOM.: E.R. - NO PENDING ORDERS DOB.....: 01/08/1977 MR#..: 422847896

REFERENCE LAB

--ORDERED--	--COLLECTED--	--REC'D--	--RESULTED--	--VERIFIED---
10/31/98 0838	10/31/98 0838	10/31/98 0846	11/02/98 1459	11/02/98 1459
CCH	CCH	FEW	LBT	LBT

GC & CHLAMYDIA DNA PROBES
SPECIMEN: MICRO SPECIMEN
LOC: ER
COLLECTED: 10/31/98 NO TIME
RECEIVED: 10/31/98 3:53PM
LOG #: E461244 REPORTED: 11/02/98 12:23PM CLIENT #: 846

TEST	RESULTS	H/L	NORMALS

REPORT NOTES: *** NON-FASTING ***
DNA PROBE: NG & CHL

N. GONORRHEA ANTIGEN	POSITIVE*		NEGATIVE
C TRACHOMATIS ANTIGEN	NEGATIVE		NEGATIVE

*** FINAL REPORT ***
Above test performed by Alabama Reference Laboratory; CLIA #: 01D0641677
Chief Medical Director R. B. Adams, M.D.

LEGEND: L-Low, H-High, C-Critical, A-Abnormal, *E*-Error

Jowel Nunn

NUNN JOWEL E.R.
360064 HORNSBY KEVIN
DOB-01/08/77 21 MALE
10/31/98
ADDRESSOGRAPH

WIREGRASS HOSPITAL
GENEVA, AL 36340
ER MEDICAL RECORD

( ) EMERGENT ( ) URGENT (X) NON-EMERGENT

TRIAGE NOTES: Yellow - Penis discharge onset last night. PAY — TIME 740

TEMP

PULSE 60

RESP 18

ALLERGIES Fish TET — WT B.P. 142/60

PRESENT MEDICATION 0 LMP SaO2

NURSE SIGNATURE [signature]

PHYSICIAN'S HISTORY AND PHYSICAL: CC penile drainage — ROS

HPI noticed yellow urethral discharge today — PMH 0

PSH hernia R ing

0 dysuria — SOCIAL occ. peanut mill

FAM Hx

ALLERGIES

MEDS

PE/VS Ro Gen : milky/purulent drainage

HEENT

CHEST/LUNGS

HEART/CV

ABD//RECTAL

GU/GYN

EXT/SKIN

NEURO

DX urethritis

PHYSICIAN'S ORDERS: CBC( ) CHEM (7)(24)

EKG( ) ABG( ) PT/PTT( ) AMYLASE( )

UA(ROUT)/(CATH) CT( )

CXR( ) F&E( ) US( )

CM( ) O2( ) FOLEY( ) IV: OTHER:

MEDICATION — INI

DISPOSITION: HOME(X) DR. OFFICE( ) SURGERY( ) EXPIRED( ) ADMIT RM#/ICU AMA/L WBS( ) DATE/TIME 840 10-31

TRANSFER TO C/O DR VIA

CONDITION AT DISCHARGE/TRANSFER: IMPROVED( ) STABLE( ) DETERIORATED( )

INSTRUCTIONS TO PT: Doxycycline 100 ē day then BID 9d

PHYSICIAN'S SIGNATURE: [signature] FAMILY DR. Simmons

NUNN JOWEL E.R.
360064 HORNSBY KEVIN
DOB-01/08/77 21 MALE
10/31/98

ER/ROOM

P PRIVATE PAY

Addressograph

WIREGRASS HOSPITAL

GENEVA, AL 36340

NURSING ASSESSMENT SHEET

DATE: 10-31 TIME: 740

MODE OF ARRIVAL: (✓)AMBULATORY ( )WHEEL CHAIR ( )STRETCHER ( )AMBULANCE ( )ARMS ALLERGIES: NKA

ACCOMPANIED BY: (✓)SELF ( ) FAMILY/FRIENDS ( )POLICE ( )OTHER FAMILY DR.:

TREATMENT PTA: ( )C COLLAR ( )SPINE BOARD ( )CID

AIRWAY: ( )ORAL ( )ET TUBE O2:_____( )NC ( )MASK

DRESSING:

IV FLUIDS:

OTHER:

TIME & INI		TIME & INI		
EKG		BREATHING TX		DR. CALLED
MONITOR		NG TUBE		DR ARRIVED
O2		DRESSING		NOTIFIED: ( )POLICE ( ) OTHER:
ABG		FOLEY		WHOM
X-RAY		OTHER		TIME

RESPIRATORY: (✓)NORMAL ( )SHALLOW ( )DEEP
( )RETRACTIONS ( )LABORED ( )RAPID ( )SLOW

BREATH SOUNDS: (✓)CLEAR ( )RALES ( )WHEEZES

COUGH: ( )NON-PRODUCTIVE ( )PRODUCTIVE

CIRCULATION: SKIN (✓)WARM (✓)DRY ( )COLD
( )DIAPHORETIC ( )HOT ( )CLAMMY

COLOR: (✓)NORMAL ( )DUSKY ( )FLUSHED ( )PALE
( )CYANOTIC ( )JAUNDICED

MENTAL STATUS: (✓)ALERT (✓)ORIENTED x3
( )DISORIENTED RESPONDS TO: (VOICE) (PAIN)
( )LETHARGIC ( )UNRESPONSIVE

PUPILS:(EQUAL)/(UNEQUAL) FIXED:(PINPOINT)/(DILATED)

SIZE: <INSERT SIZE CHART HERE>

VISUAL ACUITY: OD:_____/20 OS:_____/20

ABDOMEN: BOWEL SOUNDS: (PRESENT) (ABSENT)
( )DISTENDED ( )TENDER ( )RIGID ( )SOFT

EXTREMETIES: (✓)WNL ( )EDEMA ( )COOL ( )WARM

ROM: Y / N DEFORMITY: Y / N SENSORY: Y / N

CAPILLARY:_____sec PULSE:

GU/GYN: ( )DYSURIA ( )FREQUENCY ( )HEMATURIA
( )VAGINAL BLEEDING (✓)DISCHARGE: VAG / URETHRA

G_____P_____A_____

LACERATION: BLEEDING: Y / N SIZE:

LOCATION:

EMOTIONAL: AFFECT: (WNL) FLAT ( )COOPERATIVE

EYE CONTACT: Y / N ( )AGITATED ( )HOSTILE ( )ANXIOUS
( )COMBATIVE

NURSE:

PATIENT VALUABLES GIVEN TO_____TIME_____( )HOSP SAFE

TIME	MEDICATION	ROUTE	SITE	INI	RESPONSE

TIME	TYPE IV	RATE	SIZE	SITE	INI

NURSES NOTES: (0800) To Exam Rm - LH (0820) Dr Sibley in for exam - GC culture obtained
(840) Dc'd home c instructions verbal understanding Rx for Doxycycline

NURSES SIGNATURE:	TITLE	INI
[signature]	RN	G

ED-OP
HOME INSTRUCTION SHEET

WIREGRASS HOSPITAL
1200 W. MAPLE AVE.
GENEVA, AL 36340
205-684-3655

1. MEDICAL RECORD NO.	2. BILLING NO.	3. A/R NO.

4. CLASS	5. DATE	6. TIME	7. SRC	8. TYPE	9. SAD

10. PATIENTS LEGAL NAME (L,F,MI)	11. SEX	12. RACE	13. BIRTH DATE	14. AGE	15. HEIGHT	16. WEIGHT	17. SS	18. MS	19.
NUNN JOWEL E.R. 300064 HORNSBY KEVIN									

20. RP	21. NOTIFY IN EMERGENCY	22. HOME TELE	23. WORK TELE	24. HOW PATIENT ARRIVED
10/31/98	21 MALE			

25. C OMPLAINT	26.	27. PROC CD	28. PROCEDURE	29. LOC	30. TIME	31. ANES
ER/ROOM						

OUTPATIENT SURGERY INFORMATION

32. PHYSICIAN CALLED	33. ATTENDING PHYSICIAN	34. FAMILY PHYSICIAN
P PRIVATE PAY		

SPRAIN, FRACTURE, & SEVERE BRUISES

- ☐ Elevate the injured part above level of heart to lessen swelling. If pillows flatten, use chair cushions with pillows or blanket for comfort
- ☐ Ice packs also help prevent swelling, especially during the first 48 hours.
- ☐ Place ice in plastic or rubber bag, cloth covering; after 48 hours, use heat.
- ☐ If you have an elastic bandage, rewrap it if too tight or loose Remove at bedtime and replace in A.M
- ☐ If you have a cast, keep it perfectly dry at all times.
- ☐ Wiggle toes or fingers to help prevent swelling in the cast—this should be done often if it does not cause pain
- ☐ If the part swells anyway, or gets cold, blue or numb or pain increases markedly, have it checked promptly
- ☐ Use crutches

BACK AND NECK INJURY INSTRUCTIONS

- ☐ USE HEAT OR COLD ON THE INJURED AREA—whichever seems to help the most. Be careful not to burn yourself.
- ☐ Rest as much as possible until you are improved.
- ☐ Avoid positions and movement that make the pain worse.
- ☐ Relax emotionally—if you are tense the problem will only be worse.
- ☐ Gentle but firm massage will increase circulation in sore muscles and helps to clear the soreness
- ☐ Wear special collar when out of bed.

HEAD INJURY INSTRUCTIONS

Persons who receive blows to the head may have injuries that cannot always be seen by X-ray or examination soon after accident. For the next 24 hours it is important that these instructions be followed:

- ☐ Awaken the patient every two hours, even at night, to be sure he knows where he is and is not confused.
- ☐ Check eyes to see that both pupils are of equal size.
- ☐ Prevent the taking of sleeping pills, tranquilizers or alcohol
- ☐ Restrict excessive work or play.

Call your family doctor or local hospital immediately if the patient:

- ☐ Develops a severe headache
- ☐ Vomits more than twice within a short time.
- ☐ Is confused, faints or is hard to awaken.
- ☐ Has a pupil of one eye larger than the other
- ☐ Complains of double vision
- ☐ Shows abnormal behavior such as staggering or walking into things.

X-RAY INSTRUCTIONS

Your X-rays have been read by the attending physician in the Emergency Dept. For your added protection, your X-rays will be reread the next morning by Radiology Dept If any abnormalities are found that have not been called to your attention, you and your doctor will be called immediately (Please be certain that the Emergency Dept has a phone number where you can be reached.) Sometimes fractures or abnormalities may not show up on X-rays for several days If your symptoms continue or get worse, call your doctor. More X-rays may need to be taken If you are referred to another physician, come by the hospital and pick up your X-ray and take them with you to the doctor's office. Please call ahead to X-ray Dept.

WOUND CARE (Cuts, Abrasions, Burns, Stitches)

- ☐ Keep the dressings clean and dry
- ☐ Elevate the wound to help relieve soreness and help speed wound healing
- ☐ Despite the greatest care, any wound can be infected. If your wound becomes red, swollen, shows pus or red streaks, or feels more sore instead of less sore as days go by, you must report to your doctor right away
- ☐ Dressing should be changed in _____ days
- ☐ Treatment rendered _____
- ☐ Tetanus Toxiod given _____ 250 units of tetanus immune globulin was given To complete your immunization, you must receive two additional doses of toxoid 4-6 weeks apart. Call your physician for the next dose.
- ☐ Warm soaks to area 4 times daily, 20-40 minutes each time
- ☐ Continuous warm compresses.

VOMITING & DIARRHEA

- ☐ Do not feed anything for 4 hours
- ☐ After 4 hours, if there is no vomiting and/or diarrhea, offer 2 tablespoons (1 ounce) of any of the following clear liquids Coke, Gingerale, 7-up, weak tea, Gatorade or Jello water If patient is hungry you may add 1 teaspoon of sugar to each ounce of liquid.
- ☐ UNDER NO CIRCUMSTANCES USE MILK OR MILK PRODUCTS.
- ☐ The 2 tablespoons of liquid may be offered every hour If after 4 hours no vomiting has occurred, the amount may be slowly increased
- ☐ Using no more than ½ glass (4 ounces) of liquid at a time, continue this treatment for 24 hours.
- ☐ Contact your doctor's office for further instructions after 24 hours

GENERAL INSTRUCTIONS

- ☐ Stay in bed/may go to bathroom
- ☐ Use vaporizer
- ☐ Drink large amounts of liquids
- ☐ Take ____ aspirin every 4 hours.
- ☐ Avoid any use of injured part.
- ☐ Allow only limited use of the part.
- ☐ You need not necessarily limit activity.
- ☐ Fill Prescriptions given to you from Emergency Dept. and take as directed.
- ☐ No driving or any activity requiring mental alertness after receiving medication.

FEVER OVER 102

- ☐ Sponge with lukewarm water in the tub.
- ☐ If temperature increases or persists for 24 hours, see your family doctor.

EYE INJURY

- ☐ Any eye injury is potentially hazardous
- ☐ Any increasingly severe discomfort, redness or sudden impairment of vision should be reported immediately to your physician or eye specialist below.
- ☐ Do not drive with eye patch.

ANIMAL OBSERVATION

Instructions for observation of any animal that may have bitten a human if that animal is available for observation.

- ☐ Have animal taken to Veterinarian for observation.
- ☐ If the owner should refuse to take the animal to the Veterinarian, notify the County Health Officer of the situation.

ADDITIONAL INSTRUCTIONS Call back in 2 days for your Culture reports - Avoid

I hereby acknowledge receipt of all the instructions indicated above. I understand that I have received EMERGENCY treatment only and that I may be released before all my medical problems are known or treated. I will arrange for follow-up care as indicated above. I understand that if my conditions worsen or new symptoms appear, I should contact my Doctor immediately.

PATIENT'S SIGNATURE	NURSE'S SIGNATURE	PHYSICIAN'S SIGNATURE
Jowel Nunn		

SCHOOL AND WORK EXCUSE PATIENT NAME DATE

- ☐ No work for _____ days
- ☐ Light work for _____ days
- ☐ May return to work on _____
- ☐ No school for _____ days
- ☐ No Physical Education for _____ days
- ☐ May return to school on _____

Wiregrass Hospital PHYSICIAN'S SIGNATURE

WIREGRASS MEDICAL CENTER 1200 W MAPLE AVE GENEVA AL 36340

EMERGENCY ROOM • OUTPATIENT RECORD

PATIENT NUMBER	TYPE	PATIENT NAME	AGE	BIRTHDATE	SEX	M/S	DATE OF SERVICE	TIME	CLERK INIT.
488763	3	NUNN JOWEL	27	1/08/1977	M	SB	5/22/04	11:46	MAM

ADDRESS - LINE 1	ADDRESS - LINE 2	CITY	STATE	ZIP CODE	TELEPHONE
202 SOUTH BROAD ST		SAMSON	AL	36477	334-898-9907

PATIENT SSAN	NOTIFY IN CASE OF EMERGENCY - NAME	RELATIONSHIP	ADDRESS	TELEPHONE
422847896	NUNN LINDA FAYE	MOTHER	SAME SAMSON AL	334-898-9907

INSURANCE COMPANY	CONTRACT OR GROUP NUMBER	DATE	PLACE	ACCIDENT
		5/21/04	HOME	
		TIME	EVENT	
			FELL/INJ TO LEG	

GUARANTOR NAME	GUARANTOR ADDRESS	CITY	STATE	ZIP CODE	GUAR. TELEPHONE	GUARANTOR
NUNN JOWEL	202 SOUTH BROAD ST	SAMSON	AL	36477	898-9907	

GUARANTOR EMPLOYER	GUARANTOR OCCUPATION	GUAR. EMPLOYER ADDRESS	GUAR. EMPL TELEPHONE
SELF			

PREV. SERVICE	PREV. SERV. DATE	IF MINOR - PARENT NAME	MED. REC. #	ADMITTING/2ND PHYSICIAN
360064	10/31/98		422847896	MITCHUM O /

CHARGES	X-RAY	LAB	RESP. TH.	PHY. TH.	EKG	I.V.	DRUGS	SUPPLIES	OTHER	M.D.	E.R. RM	TOTAL DUE

AUTHORIZATION FOR TREATMENT, GUARANTEE OF PAYMENT , ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned has been informed of the emergency treatment considered necessary for the above named patient, and that treatment and procedures will be performed by physicians, members of house staff and employees of the hospital. Authorization is hereby granted for such treatment and procedures. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained.
2. The undersigned agrees to pay for services rendered by Hospital upon release of patient.
3. I/we hereby assign any hospital benefits, sick benefits, injury benefits due to a liability of a Third party, payable by any party, for the above patient, to Hospital unless I pay the account in full upon release of patient.
4. I/we hereby authorize the "Administrator of Hospital" to furnish from its records any information requested by the before mentioned insurance companies in connection with the above assignment. I do hereby appoint the "Controller" of Hospital as my lawful attorney to endorse for me any checks made payable to me for benefits or claims collected under the above assignment and to apply any credit balance to any other account I may owe said hospital.

DATE TIME SIGNED PATIENT SIGNED GUARANTOR

CHIEF COMPLAINT (If Accident State How, When, and Where)
FELL/INJ TO SHOULDER/ARM/LEG

TEMP.	PULSE	RESP.	B/P	ALLERGIES	MEDICATIONS - HOME	E.R. PHYSICIAN	TET. TOX.

NURSES NOTES:

NURSE'S SIGNATURE (RN OR LPN)

LAB DATA (Including X-Rays, EKGs, etc.)

PHYSICIAN'S REPORT

DIAGNOSIS:

TREATMENT:

CONDITION ON DISC: IMP | STABLE | EXPIRED

INSTRUCTIONS TO PATIENT:

FOLLOW-UP WITH M.D.

M.D.

PATIENT'S SIGNATURE ON DISCHARGE
BY SIGNING HERE I CERTIFY THAT I UNDERSTAND THE FOLLOW-UP INSTRUCTIONS RECEIVED BY ME IN WRITING, WHICH WERE EXPLAINED TO ME.

DATE - TIME OF DISC.

PHYSICIAN'S SIGNATURE

Wiregrass Medical Center
1200 W. Maple Avenue
Geneva, Alabama 36340

CONDITIONS FOR TREATMENT

#488763 Nurse Jewel

1. **MEDICAL AND SURGICAL CONSENT FOR TREATMENT:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to furnish the necessary treatment, surgical procedures, anesthesia, x-ray examinations or treatments, drugs and supplies as may be ordered or requested by the attending physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery or examinations in the hospital. The undersigned recognizes that all physicians furnishing services to the patient may be independent contractors and are not employees or agents of the Hospital.

2. **RELEASE OF INFORMATION:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to release to any insurers, their representatives or other third parties confidential information (including copies of records) relative to this hospitalization. This authorization includes, but is not limited, to the release of information relating to drug, alcohol and or psychiatric treatment as specified in Federal Regulation 42, CFR part 2. I further authorize any physician or institution that attended the patient previously to furnish medical records or information which may be requested by the Hospital or attending physicians.

3. **RELEASE FROM LIABILITY FOR VALUABLES:** I have been made aware the WIREGRASS MEDICAL CENTER provides facilities for the safe keeping of my valuables and therefore, I release the Hospital from any responsibility due to loss or damage of my clothing, money, jewelry, or other items of value that I might keep at my bedside, or that may be brought to me by my friends and relatives.

4. **GUARANTOR AGREEMENT:** The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.

5. **ASSIGNMENT OF INSURANCE BENEFITS:** In the event the undersigned and/or patient is entitled to Hospital benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to WIREGRASS MEDICAL CENTER for application to the patient's bill. It is agreed that the Hospital may receipt for any such payment and such payment will discharge the said insurance company of all obligations under the policy to the extent of such payment. The undersigned and/or patient agrees to be responsible for charges not paid by this assignment.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ OR HAD THE FOREGOING INFORMATION EXPLAINED, HAS RECEIVED A COPY, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Date 5-22- 20 04 x Jewell S. Nunn
Patient

Witness Mary Mitts

Patient's Agent or Representative

Relationship to Patient

ASSIGNMENT OF MEDICARE BENEFITS:
PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST

"I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for Part A deductible for each spell of illness, the Part B deductible for each year, the remaining 20% of reasonable charges and any personal charges incurred."

Date Signature Relationship to Patient

ACKNOWLEDGEMENT OF MEDICARE

I hereby declare I am a participant in the Medicare Program and I am not enrolled in a health maintenance organization, (H.M.O.), or any other pre-paid group practice. I understand that if it is found that I am a participant in any of the above mentioned practices, I will be considered a self-pay patient required to pay in full immediately.

Date Signature Relationship to Patient

WIREGRASS MEDICAL CENTER

Billing Form

For Financial Class:

P

Patient Name..... NUNN, JOWEL
Admission Date..... 05/22/2004
Medical Record Number..... 422847896
Age..... 27
Account Number..... 488763

Discharge Date..... 05/22/2004
Date of Birth..... 01/08/1977
Sex..... Male

DX	Code	DX Description
1	923.8	Contusion of Multiple Sites of Upper Limb
2	E819.2	MV Traffic Accident NOS Injuring Motorcyclist

PR	Code	PR Description	Procedure Date	Surgeon

CPT	Code	CPT Modifiers	CPT Description	CPT Date	CPT Surgeon
		APC PSI	Payment Rate	ASC Group	ASC Fee

Attending Physician..... 000700
Consulting Physician.....
Discharge Disposition..... 01 - Home
DRG =
Status.....

Memo
DRG

MDC	Weight	AMLOS	GMLOS	LOS

PRINT DATE: 05/23/04 902 Wiregrass Medical Center PAGE 1
Ed Benak M.D. 01D0304961
Medical Director CLIA Number
TIME: 13:00 LABORATORY --- CUMULATIVE REPORT H5LACUMV

NAME.: NUNN JOWEL SEX.....: M PHY..: MITCHUM O D MD
ACCT#: 488763 AGE.....: 27 Y ADMIT: 05/22/04
ROOM.: E.R. - NO PENDING ORDERS DOB.....: 01/08/1977 MR#..: 422847896
PAT. PHONE: 3348989907

HEMATOLOGY

	05/22/04 1235	REFERENCE RANGE	UNITS
WBC	9.8	4.3 - 11.0	K/uL
RBC	4.71	4.60 - 6.20	M/uL
HEMOGLOBIN	14.5	14.0 - 18.0	gm/dL
HEMATOCRIT	42.8	38.0 - 56.0	%
MCV	90.9	80.0 - 94.0	fL
MCH	30.7	26.0 - 33.0	pg
MCHC	33.8	31.0 - 36.0	gm/dL
PLATELETS	223	150 - 375	k/uL
RDW	12.1	10.2 - 15.5	%
MPV	9	7 - 10	fl
NEUTROPHILS%	67	50 - 87	%
LYMPHOCYTES%	22	16 - 46	%
MONO%	7.0	5.5 - 11.7	%
EO%	1	0 - 2	%
BA%	**3 H**	0 - 1	%
NEUTROPHILS#	6.5	1.5 - 7.1	K/uL
LYMPHS#	2.2	.8 - 2.8	K/uL
MONO#	0.7	.3 - .8	K/uL
EO#	0.1	.0 - .2	K/uL
BA#	**0.3 H**	.0 - .1	K/uL
DIFF	NOT INDICATED		

URINALYSIS

	05/22/04 1211	REFERENCE RANGE	UNITS
Clarity	Clear	Clear	
Color	Yellow	Yellow	
Glucose	Negative	Negative	
Bilirubin	Negative	Negative	
Ketones	Trace	Negative	
Sp Gravity	>=1.030	1.003 - 1.030	
Blood	Small	Negative	
ph	6.0		
Protein	30	Negative	
Urobilinogen	1.0		
Nitrite	Negative	Negative	
Leuk Esterase	Negative	Negative	
MICROSCOPIC	SEE BELOW		
Wbc	RARE	None Seen	
Rbc	4-6	None Seen	

LEGEND: L-Low, H-High, C-Critical, A-Abnormal, *E*-Error

WIREGRASS MEDICAL CENTER

1200 WEST MAPLE AVENUE
GENEVA, ALABAMA

RADIOLOGY REPORT

NAME: NUNN JOWEL
AGE: 27 **SEX:** M
DOB: 01/08/1977
STAY TYPE: E.R. ROOM:
ADMIT DATE: 05/22/04
ACCT NUMBER: 488763
LOCATION:
TRANS DATE: 5/24/04

PATIENT PHONE: 334/898/9907
ORDERING PHY: MITCHUM O
ADMITTING PHY: MITCHUM O
REFERRING PHY:
FAMILY PHY:
XRAY NUMBER: 2604
MR NUMBER: 422847896
TRANS INITIALS: SR

<=X-RAY ORDER=> COMPLETE:05/22/04 12:27 SAD 76956
Reason for Procedure: INJURY
SHOULDER MIN 2V 73030 COMPLETE:05/22/04 12:27 SAD 76957

*** UNSIGNED TRANSCRIPTIONS REPRESENT A PRELIMINARY REPORT AND DOES ****** NOT REFLECT A MEDICAL OR LEGAL DOCUMENT ***

LEFT SHOULDER AND SCAPULA 2 VIEWS: THE AC JOINT IS INTACT. THERE IS NO DEFINITE FRACTURE OR DISLOCATION IDENTIFIED.

OPINION: UNREMARKABLE EXAM.

JOHN C. TOMBERLIN, M.D.

Jowel Nunn
1/8/77

NUNN JOWEL
488763 MITCHUM O D MD
DOB-01/08/77 27 MALE
Addressograph

E.R.

Wiregrass Medical Center

ER Medical Record ( ) Emergent (X) Urgent ( ) Non-Emergent

Triage/Notes: was involved in motorcycle accident yesterday	Time: 1140
large abrasions left upper arm and left shoulder.	Temp: 98.8
hematoma left side of head c/o pain Tet: 2002 Wt: 280 Pounds	Pulse: 100
Allergies: NKA LMP: SpO2: 98%	Resp: 20
Meds: None	BP: 143/101
Nurse Signature: Debra [illegible] RN	

H&P and CC:	PMH:
HPI: As above	Surg:
	Social/Habits:
General: large abrasion, [illegible] shoulder [illegible]	Family Hx:
HEENT [illegible] bump. Tender.	ROS / Neg / Document if positive
Neuro:	
Heart:	Neuro/Psych: ☐
Lungs:	Cardio/Resp: ☐
Musculoskeletal: Dx: Contusion.	GU: ☐
Abd/Rectal:	Other: ☐
GU/Gyn: Rx: [illegible] [illegible] [illegible]	
Ext/Skin:	
Dx:	

Physician's Orders:	CBC( )	BMP/CMP	Medication	Ini
EKG( )	ABG( )	PT/PTT( )		
UA(Rout)(Cath)	CT( )	Amylase( )		
CXR(X) Lt shoulder scapula	Other Studies	US( )		
CM( )	O2( )	Foley( ) IV:		

Disposition: Home(X) Dr. Office( ) Surgery( ) Expired( ) Adm Rm# AMA/LWBS( ) Date/Time: 5/22/04 1315

Transfer to C/O Dr. Via

Condition at Discharge/Transfer: Improved( ) Stable(X) Deteriorated( ) Unchanged( )

Instructions to Pt: (1) Rx:

(2) Instructions:

(3) Follow up:

Signing this form denotes that I have reviewed all information on this document and I agree:

Physician's Signature: **Family Dr.** None

E.R.

NUNN JOWEL
488763 HITCHUM O D MD
DOB-01/08/77 27 MALE
05/22/04

ER/ROOM

Addressograph

Wiregrass Medical Center
Emergency Department
Nursing Assessment

Mode of Arrival: ☑ Ambulatory ☐ Stretcher ☐ Ambulance ☐ Arms
☐ Other: _____

Accompanied By: ☐ Self ☑ Family/Friend ☐ Police ☐ Other
Immunizations up to date? ☑ Y ☐ N

Developmental Age Same as Stated Age ☑ Yes ☐ No

How do you prefer to learn? Written ☐ Verbal ☐ Combination ☑

Initial Contact Time: 1140 Allergies: NKA
Date: 5/22/04

Treatment/RCA

None ☐ Cervical Collar ☐ Spineboard: ☐ Splint ☐ Dressings ☑ Shoulder

IV Fluids: _____ Rate: _____ Site: _____

Airway: None ☑ Oral ☐ ET Tube ☐ ☐ Oxygen _____ via ☐ NC ☐ Mask

Nutritional Assessment

Are you on a regular diet? ☑ Y ☐ N

Have you had a recent weight loss or gain? ☐ Y ☑ N

Comments: _____

Respiratory

Respirations: ☑ Regular ☐ Irregular ☐ Shallow ☐ Deep

Breath Sounds: ☐ Bil. Clear ☐ Rhonchi ☐ Rales ☐ Wheezes

Cough: ☐ Productive ☐ Nonproductive

Sternal Retractions? ☐ Yes ☑ No

Dyspnea? ☐ Yes ☑ No

Comments: _____

Circulation

Skin: ☑ Warm ☑ Dry ☐ Hot ☐ Diaphoretic ☐ Cold ☐ Clammy

Color: ☑ Normal ☐ Pink ☐ Dusky ☐ Flushed ☐ Pale ☐ Cyanotic ☐ Jaundice

Edema: ☐ Yes ☑ No

JVD: ☐ Yes ☑ No

Capillary Refill: ☑ Quick ☐ Slow

Comments: _____

Glasgow Coma Scale

Eyes Open:	Spontaneously	4
	To Verbal Command	3
	To Pain	2
	No Response	1
Best Motor Response	Obeys	6
	Localizes Pain	5
	Flexion-Withdrawal	4
	Flexion/Abnormal (Decorticate Rigidity)	3
	Extension (Decerebrate Rigidity)	2
	No Response	1
Best Verbal Response	Oriented/Converses	5
	Disoriented/Converses	4
	Inappropriate Words	3
	Incomprehensible Sounds	2
	No Response	1
GCS Total (3-15):		15

Neurological

Level of Consciousness: ☑ Alert ☐ Responds to Voice ☐ Responds to Pain ☐ Unresponsive ☐ Lethargic

Orientation: ☑ Appropriate Response ☐ Inappropriate Response

Pupils: Brisk ☐ L ☐ R Sluggish ☐ L ☐ R Nonreactive ☐ L ☐ R

Size: L:_____ R:_____

Visual Acuity: ☐ N/A OD:_____ OS:_____

Movement: ☐ Voluntary ☐ Involuntary

Hand Grasp: L R
Strong ☑ ☑
Weak ☐ ☐
Absent ☐ ☐

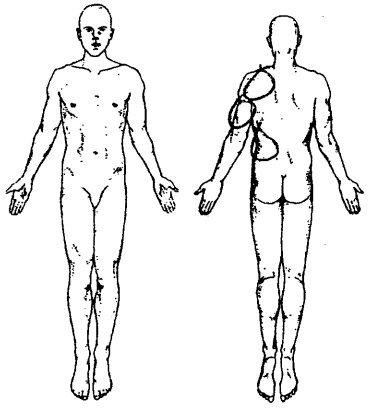
Slurred Speech? ☐ Yes ☑ No

Abdominal

☐ Distended ☐ Nausea
☐ Vomiting ☐ Diarrhea
☐ Constipation ☐ LBM:_____
Bowel Sounds: ☑ Present ☐ Absent

Comments: _____

Pain/Injury Location



Location (circled above)

Radiation (arrow above)

Extremities

Location(s): _____

Size(s): _____

Bleeding Controlled: ☐ Yes ☐ No

Comments: _____

Full Range of Motion ☐ Y ☐ N

Pulse: _____ ☐ Y ☐ N

Sensation Intact: ☐ Y ☐ N

GU/GYN

Pain in Voiding: ☐ Yes ☐ No

Frequency ☐ Yes ☐ No

Bleeding: ☐ Yes ☐ No

Vaginal Bleeding ☐ Yes ☐ No

Vaginal Discharge ☐ Yes ☐ No

☐ Scant ☐ Moderate ☐ Large

Grav_____ Para_____ Ab_____

Comments: _____

Orthopedic

Ext Deformity: ☐ Yes ☐ No

Full ROM: ☐ Yes ☐ No

Pulse: _____

Cap. Refill: ☐ Brisk ☐ Slow

Temp: ☐ Warm ☐ Cold

Sensation Intact: ☐ Yes ☐ No

Emotional Assessment

Eye Contact ☑ Y ☐ N

Affect: ☑ Normal ☐ Flat ☑ Cooperative ☐ Disoriented ☐ Combative ☐ Anxious

Do you feel safe in your present living environment?
☑ Yes ☐ No

If no, would you like to talk to someone? ☐ Yes ☐ No

Comments: _____

Pain Assessment

Severity: _____
0 1 2 3 4 (5) 6 7 8 9 10

Exacerbated By: _____

Relieved By: Nothing ☐ Pt unable to rate

Nursing Signature

Debra Tuck RN

401A

Medications

Time	Medication	Rte	Site	Init	Response

IV Fluids

Time	Type of Fluid	Cath Size	Rate	Site	Initial

Pain Assessment/Reassessment

Pain Intensity: 0 1 2 3 4 (5) 6 7 8 9 10
☐Pt unable to rate
Time: 1315 Location:
Intervention: Rx given
Initials: DA

Pain Intensity: 0 1 2 3 4 5 6 7 8 9 10
☐Pt unable to rate
Time: Location:
Intervention:
Initials:

Pain Intensity: 0 1 2 3 4 5 6 7 8 9 10
☐Pt unable to rate
Time:
Location:
Intervention:
Initials:

Vital Signs

Time	Temp	Pulse	RR	B/P	SaO2

Procedure/Treatment	Time	Ini
Cardiac Monitor		
O2 Type ___ Rate: ___		
EKG		
Xray Type [illegible] Scapula CXR		
Location: indept	1220	DA
Dressing Type:		
Location:		
Splint Type:		
Location:		
Foley:		
N/G Tube:		
Other:		

Nurses Notes

1150 - to treatment room - DA 1215 - Dr. Mitchum in to evaluate - orders received - DA 1230 - returned from X-ray via W/C DA - 1235 blood drawn for lab - urine specimen obtained DA 1300 Dr. Mitchum in - reviewed labwork and Xray DA 1310 - abrasion cleaned c̄ betadine and saline, triple antibiotic ointment applied - tolerated well DA 1315 - discharge instructions written and verbal given to pt - verbalized understanding. discharged ambulatory in stable condition DA

Notified: Time:
☐Police ☐Med. Examiner
☐Family/Friend ☐Health Dept.
☐Other (Whom:)
☐Valuables given to:
☐Sent Home

Intake: IV		Output: NG	
PO		Urine	
Other		Other	
Total		Total	

Nurse's Signature/Title	Init
Debra [illegible] RN	DA

ER/ROOM

05/22/04
DOB-01/08/77 27 MALE
488763 MITCHUM O D MD
NUNN JOWEL
E.R.

WIREGRASS MEDICAL CENTER

1200 W. MAPLE AVE.
GENEVA, AL 36340
(334) 684-3655

ED-OP
HOME INSTRUCTION SHEET

1. MEDICAL RECORD NO.	2. BILLING NO.	3. A/R NO.

INFORMATION

4. CLASS	5. DATE	6. TIME	7. SRC	8. TYPE	9. SAD

10. PATIENTS LEGAL NAME (L,F,MI)	11. SEX	12. RACE	13. BIRTHDATE	14. AGE	15. HEIGHT	16. WEIGHT	17. SS	18. MS	19.
NUNN JOWEL	E	R.							

20. RP	21. NOTIFY IN EMERGENCY	22. HOME TELE	23. WORK TELE	24. HOW PATIENT ARRIVED
	DOB-01/06/77 27 MALE			

25. C COMPLAINT/ 26: 05/22/04 ER/ROOM

OUTPATIENT SURGERY INFORMATION

27. PROC CD	28. PROCEDURE	29. LOC	30. TIME	31. ANES

32. PHYSICIAN CALLED	33. ATTENDING PHYSICIAN	34. FAMILY PHYSICIAN

SPRAIN, FRACTURE, & SEVERE BRUISES

- ☐ Elevate the injured part above level of heart to lessen swelling. If pillows flatten, use chair cushions with pillows or blanket for comfort.
- ☐ Ice packs also help prevent swelling, especially during the first 48 hours.
- ☐ Place ice in plastic or rubber bag, cloth covering; after 48 hours, use heat.
- ☐ If you have an elastic bandage, rewrap it if too tight or loose. Remove at bedtime and replace in A.M.
- ☐ If you have a cast, keep it perfectly dry at all times.
- ☐ Wiggle toes or fingers to help prevent swelling in the cast–this should be done often if it does not cause pain.
- ☐ If the part swells anyway or gets cold, blue or numb or pain increases markedly, have it checked promptly.
- ☐ Use crutches.

BACK AND NECK INJURY INSTRUCTIONS

- ☐ USE HEAT OR COLD ON THE INJURED AREA - whichever seems to help the most. Be careful not to burn yourself.
- ☐ Rest as much as possible until you are improved.
- ☐ Avoid positions and movement that make the pain worse.
- ☐ Relax emotionally - if you are tense the problem will on be worse.
- ☐ Gentle but firm massage will increase circulation in sore muscles and helps to clear the soreness.
- ☐ Wear special collar when out of bed.

HEAD INJURY INSTRUCTIONS

Persons who receive blows to the head may have injuries that cannot always be seen by X-ray or examination soon after accident. For the next 24 hours it is important that these instructions be followed:

- ☐ Awaken the patient every two hours, even at night, to be sure he knows where he is and is not confused.
- ☐ Check eyes to see that both pupils are of equal size.
- ☐ Prevent the taking of sleeping pills, tranquilizers or alcohol.
- ☐ Restrict excessive work or play.

Call your family doctor or local hospital immediately if the patient:

- ☐ Develops a severe headache.
- ☐ Vomits more than twice within a short time.
- ☐ Is confused, faints or is hard to awaken.
- ☐ Has a pupil of one eye larger that the other
- ☐ Complains of double vision
- ☐ Shows abnormal behavior such as staggering or walking into things.

X-RAY INSTRUCTIONS

Your X-rays have been read by the attending physician in the Emergency Dept. For your added protection, your X-rays will be reread the next morning by Radiology Dept. If any abnormalities are found that have not been called to your attention, you and your doctor will be called immediately. (Please be certain that the Emergency Dept. has a phone number where you can be reached.) Sometimes fractures or abnormalities may not show up on X-rays for several days. If your symptoms continue or get worse, call your doctor. More X-rays may need to be taken. If you are referred to another physician, come by the hospital and pick up your X-ray and take them with you to the doctor's office. Please call ahead to X-ray Dept.

WOUND CARE (Cuts, Abrasions, Burns, Stitches)

- ☐ Keep the dressings clean and dry.
- ☐ Elevate the wound to help relieve soreness and help speed wound healing.
- ☐ Despite the greatest care, any wound can be infected. If your wound becomes red, swollen, shows pus or red streaks, or feels more sore instead of less sore as days go by, you must report to your doctor right away.
- ☐ Dressing should be changed in _____ days.
- ☐ Treatment rendered _____.
- ☐ Tetanus Toxiod given _____. 250 units of tetanus immune globulin was given. To complete your immunization, you must receive two additional doses of toxoid 4-6 weeks apart. Call your physician for the next dose.
- ☐ Warm soaks to area 4 times daily. 20-40 minutes each time.
- ☐ Continuous warm compresses.

VOMITING & DIARRHEA

- ☐ Do not feed anything for 4 hours.
- ☐ After 4 hours, if there is not vomiting and/or diarrhea, offer 2 tablespoons (1 ounce) of any of the following: clear liquids, Coke, Gingerale, 7-up, weak tea, Gatorade or Jello, water. If patient is hungrey you may add 1 teaspoon of sugar to each ounce of liquid.
- ☐ UNDER NO CIRCUMSTANCES USE MILK OR MILK PRODUCTS.
- ☐ The 2 tablespoons of liquid may be offered every hour. If after 4 hours no vomiting has occured, the amount may be slowly increased.
- ☐ Using no more than ½ glass (4 ounces) of liquid at a time continue this treatment for 24 hours.
- ☐ Contact your doctor's office for further instructions after 24 hours.

GENERAL INSTRUCTIONS

- ☐ Stay in bed/may go to bathroom.
- ☐ Use vaporizor.
- ☐ Drink large amounts of liquids.
- ☐ Take _____ aspirin every 4 hours..
- ☐ Avoid any use of injured part.
- ☐ Allow only limited use of the part.
- ☐ You need not necessarily limit activity.
- ☒ Fill Prescriptions given to you from Emergency Dept. and take as directed.
- ☒ No driving or any activity requiring mental alertness after receiving medication.

FEVER OVER 102

- ☐ Sponge with lukewarm water in the tub.
- ☐ If temperature increases or persists for 24 hours, see your family doctor.

EYE INJURY

- ☐ Any eye injury is potentially hazardous.
- ☐ Any increasingly severe discomfort, redness or sudden impairment of vision should be reported immediately to your physician or eye specialist below.
- ☐ Do not drive with eye patch.

ANIMAL OBSERVATION

Instructions for observation of any animal that may have bitten a human if that animal is available for observation.

- ☐ Have animal taken to Vetennarian for observation.
- ☐ If the owner should refuse to take the animal to the Vetennarian, notify the County Health Officer of the situation.

ADDITIONAL INSTRUCTIONS Wash abrasions with no tear baby shampoo daily - apply antibiotic ointment 2-3 times/day

I hereby acknowledge receipt of all the instructions indicated above. I understand that I have received EMERGENCY treatment only and that I may be released before al my medical problems are known or treated. I will arrange for follow-up care as indicated above. I understand that if my conditions worsen or new symptoms appear, I should contact my Doctor immediately.

PATIENT/PARENT'S SIGNATURE X Jowell S N NURSE'S SIGNATURE Debra Ard RN PHYSICIAN'S SIGNATURE

SCHOOL AND WORK EXCUSE *PATIENT NAME* *DATE*

- ☐ No work for _____ days
- ☐ Light work for _____ days
- ☐ May return to work on _____
- ☐ No school for _____ days
- ☐ No Physical Education for _____ days
- ☐ May return to school on _____

WIREGRASS MEDICAL CENTER PHYSICIAN'S SIGNATURE

ADVANCE DIRECTIVE
ACKNOWLEDGEMENT

NAME: Nunn, Jewel SOC. SEC. NO: 422-84-4896
IDENTIFICATION NO: 488763 DATE OF BIRTH: 1-8-1977

PLEASE READ THE FOLLOWING FOUR STATEMENTS.

1. I have been given written materials about my right to accept or refuse medical treatments

2. I have been informed of my rights to formulate Advance Directives.

3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility.

4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

☐ **I HAVE** executed an Advance Directive.

☒ **I HAVE NOT** executed an Advance Directive.

Signed Jewel S Nunn Date: 5-22-04

Witness:_____ Date:_____

Witness: Mary Miller Date: 5-22-04

Form # 390 Advance Directive Acknowledgement

Wiregrass Medical Center
ER Level of Service Charge Sheet

NUNN JOWEL E.R.
488763 MITCHUM O D MD
DOB-01/08/77 27 MALE
05/22/04

ER/ROOM

Circulatory		
Jugular,Cutdown, Central Line		
Blood Administration	19636430	
Cardioversion, Mechanical	19692960	
Code Blue	19692950	
External Pacemaking	19692953	
Intubation	19631500	
Immunization (Td, Hepatitis B)		
Immunization (Rabies)	19690675	
Medication Administration IV	19690784	
Medication Administration IM or SQ	19690782	
Paracentesis	19649080	
Peritoneal Lavage/Tap		
Thoracentesis	19632000	
Pericardiocentesis	19633010	
Chest Tube Insertion	19632002	
IV Hydration		
CPR		
ENT		
Eye Irrigation		
Eye Exam/Corneal Abrasion		
Foreign Body Removal Ear		
Foreign Body Removal Nose		
Irrigation Ear		
Nose Bleed/Nasal Packing		
Rust Ring (Foreign Body Removal)		
Respiratory		
Tracheotomy	19631603	
Cricothyrotomy	19631605	
Trach Change	19631603	
Gastrointestinal		
Gastric Lavage or NGT insertion	19691105	
Gastrostomy Tube Placement	19643760	
Genitourinary		
Delivery/Birth	19659409	
Supra Pubic Cath, or Turkey Tray		
Irrigation of Catheter	19651700	
Pelvic Exam		

Integumentary		
Repair of Nail Bed	19611760	
Subungal Hematoma	19611740	
Dressing Application		
FB removal	19610120	
I&D Abcess	19620000	
Laceration Repair (simple,intermed)	19600000	
Laceration Complex	19610000	
Debridement	19611040	
Treatment of Burns	19616020	
Orthopedics		
Behr Block/Regional Block		
Casting/Splinting	19629500	
Removal or Revision of Cast	19629705	
Tx of fx/dislocation with manipulation		
Compartmental Syndrome	19620950	
Neurological		
Lumbar Puncture	19662290	
Treatment Level		
Emergency WD	19699281	
Emergency I	19699282	
Emergency I with procedure		
Emergency II	19699283	✓
Emergency II with procedure		
Emergency III	19699284	
Emergency III with procedure		
Emergency IV	19699285	
Emergency IV with procedure		
Critical Care	19699291	
Critical Care with procedure		
Observation I		
Observation II		
Observation III		

Wiregrass Medical Center

Emergency Physician's Charge Sheet Date:

NUNN JOWEL E.R.
488763 MITCHUN O D MD
DOB-01/08/77 27 MALE
05/22/04

ER/ROOM

	Level of Service
19599281	Level I
19599282	Level II
19599283	Level III
19599284	Level IV
19599285	Level V
19599288	Direct Life Support In Transit
19599025	Visit with Surgery
19599291	Critical Care per Hour
19599292	Critical Care per 1/2 hour
19591105	NG Lavage/Aspiration
19599175	Ipecac Admin/Observe Gastric emptying

	Airway/Pulmonary
19531500	Endotracheal Intubation
19531511	FB Removal
19532020	Tube Thoracostomy

	Vascular Procedures
19536410	Non-Routine Venipuncture
19590780	IV Therapy Requiring MD per hour
19592977	Thrombolysis IV infusion

	Cardiac Procedures
19592950	CPR
19592953	Transcutaneous Pacing
19592960	Cardioversion, Elective

	Opthamology
19565205	FB
19565210	FB Conjunctival/Embedded
19567938	FB, Eyelid

	Ear,Nose, and Throat
19542809	FB Pharynx
19569200	FB External Ear Canal
19569210	Impacted Cerumen
19530300	FB Intranasal
19530901	Anterior Epitaxis, Simple
19530903	Anterior Epitaxis, Complex
19530905	Posterior Epitaxis, Initial

	Soft Tissue/Foreign Body Removal
19510120	Sub Q, Simple
19510121	Sub Q, Complicated
19520520	Muscle, Simple
19520525	Muscle, Complex

	Nails
19511730	Avulsion/Nail, Simple
19512740	Subungal Hematoma

	Debridement
19511000	Infected Skin
19511040	Partial Skin Thickness
19511041	Skin, Full Thickness
19511042	Skin and Sub Q Tissue
19511043	Skin, Sub Q, Muscle
19511044	Skin, Sub Q, Muscle, Bone

	Hematoma and Abcess
19510060	I&D Simple Abcess, Furuncle
19510061	I&D Simple Abcess, Complicated/ Multiple
19510140	I&D Hematoma Simple
19510160	I&D Puncture Aspiration, Abcess
19546320	Hemorrhoid, Thrombosed

	Burns
19516000	First Degree Burn, Initial
19516020	Small Burn, Debride,Dress
19516025	Medium Burn, Debride/Dress
19516030	Large Burn, Debride/Dress

	OB/GYN Procedures
19556405	I&D, Abcess, Vulva
19556420	I&D, Bartholin Abcess
19559410	Emergency Vaginal Delivery

	Arthrocentesis
19520600	Arthrocentesis, Small Joint
19520605	Arthrocentesis, Intermediate Joint
19520610	Arthrocentesis, Major Joint

	Miscellaneous Fractures
19521800	Closed Rib Fracture
19523500	Clavicle
19526750	Closed Distal Phalangeal
19528490	Closed Fracture, Great Toe
19528510	Closed Phalanx other than Gr. Toe

	Miscellaneous Closed Dislocations
19521480	TMJ Uncomplicated
19523650	Shoulder w/ Manipulation
19524640	Nursemaid's Elbow
19526700	Finger, MP Joint
19526770	Finger, IP Joint
19528660	Toe IP Joint

	Miscellaneous Procedures
19553670	Urine Catheterization, Simple
19553675	Urine Catheterization, Complex
19562270	Spinal Puncture
19564450	Digital Block
19582270	Stool for Occult Blood
19593042	Rhythm Strip Interpretation

	Repair/Simple- Single Layer
	Scalp, Neck, Axillate, External Genitalia, Trunk, and/or extremities
19512001	2.5 cm or less
19512002	2.6 - 7.5 cm
19512004	7.6 - 12.5 cm
19512005	12.6 - 20.0 cm
19512006	20.1 - 30.0 cm
19512007	Over 30.0 cm

	Repair/Simple- Single Layer Cont'd
	Face, Ears, Eyelids, Nose, Lips, and/or Mucous Membranes
19512011	2.5 cm or less
19512013	2.6 - 5.0 cm
19512014	5.1-7.5 cm
19512015	7.6 - 12.5 cm
19512016	12.6 - 20.0 cm
19512017	20.1 - 30.0 cm
19512018	Over 30.0 cm
19512020	Superficial WD Dehis
19512021	Superficial WD Dehis-Pack

	Repair/Intermediate-Layered
	Scalp, Axillae, Trunk, and/or Extremities
19512031	2.5 cm or less
19512032	2.6 - 7.5 cm
19512034	7.6 - 12.5 cm
19512035	12.6 - 20.0 cm
19512036	20.1 - 30.0 cm
19512037	Over 30.0 cm
	Neck, Hand, Feet, and/or External Genitalia
19512041	2.5 cm or less
19512042	2.6 - 7.5 cm
19512044	7.6- 12.5 cm
19512045	12.6 - 20.0 cm
19512046	20.0 - 30.0 cm
19512047	Over 30.0 cm
	Face, Ears, Eyelids, Nose, Lips, and/or Mucous Membranes
19512051	2.5 cm or less
19512052	2.6 - 5.0 cm
19512053	5.1 - 7.5 cm
19512054	7.6 - 12.5 cm
19512055	12.6 - 20.0 cm
19512056	20.1 - 30.0 cm
19512057	Over 30.0 cm

	Repair/Complex-Reconstructive or Complicated Wound Closure
	Trunk
19513100	1.1 - 2.5 cm
19513101	2.6 - 7.5 cm
	Scalp, Arms, and/or Legs
19513120	1.1 - 2.5 cm
19513121	2.6 - 7.5 cm
	Forehead, Cheeks, Chin, Mouth, Neck, Axillae, Genitalia, Hands, and or Feet
19513132	1.1 - 7.5 cm
	Eyelids, Nose, Ears, and/or Lips
19513151	1.1 - 2.5 cm
19513152	2.6 - 7.5 cm

WIREGRASS MEDICAL CENTER 1200 W MAPLE AVE GENEVA AL 36340

EMERGENCY ROOM • OUTPATIENT RECORD

PATIENT NUMBER	TYPE	PATIENT NAME	AGE	BIRTHDATE	SEX	M/S	DATE OF SERVICE	TIME	CLERK INIT.
488813	3	NUNN JOWEL	27	1/08/1977	M	SB	5/23/04	21:45	DWP

ADDRESS - LINE 1	ADDRESS - LINE 2	CITY	STATE	ZIP CODE	TELEPHONE
202 SOUTH BROAD ST		SAMSON	AL	36477	334-898-9907

PATIENT SSAN	NOTIFY IN CASE OF EMERGENCY - NAME	RELATIONSHIP	ADDRESS	TELEPHONE
422847896	NUNN LINDA FAYE	MOTHER	SAME SAMSON AL	334-898-9907

INSURANCE COMPANY	CONTRACT OR GROUP NUMBER	DATE	PLACE	ACCIDENT
		TIME	EVENT	

GUARANTOR NAME	GUARANTOR ADDRESS	CITY	STATE	ZIP CODE	GUAR. TELEPHONE	GUARANTOR
NUNN JOWEL	202 SOUTH BROAD ST	SAMSON	AL	36477	898-9907	

GUARANTOR EMPLOYER	GUARANTOR OCCUPATION	GUAR. EMPLOYER ADDRESS	GUAR. EMPL TELEPHONE
SELF			

PREV. SERVICE	PREV. SERV. DATE	IF MINOR - PARENT NAME	MED. REC. #	ADMITTING/2ND PHYSICIAN
488763	5/22/04		422847896	MITCHUM O /

CHARGES	X-RAY	LAB	RESP. TH.	PHY. TH.	EKG	I.V.	DRUGS	SUPPLIES	OTHER	M.D.	E.R. RM	TOTAL DUE

AUTHORIZATION FOR TREATMENT, GUARANTEE OF PAYMENT , ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned has been informed of the emergency treatment considered necessary for the above named patient, and that treatment and procedures will be performed by physicians, members of house staff and employees of the hospital. Authorization is hereby granted for such treatment and procedures. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained.
2. The undersigned agrees to pay for services rendered by Hospital upon release of patient.
3. I/we hereby assign any hospital benefits, sick benefits, injury benefits due to a liability of a Third party, payable by any party, for the above patient, to Hospital unless I pay the account in full upon release of patient.
4. I/we hereby authorize the "Administrator of Hospital" to furnish from its records any information requested by the before mentioned insurance companies in connection with the above assignment. I do hereby appoint the "Controller" of Hospital as my lawful attorney to endorse for me any checks made payable to me for benefits or claims collected under the above assignment and to apply any credit balance to any other account I may owe said hospital.

DATE TIME SIGNED PATIENT SIGNED GUARANTOR

CHIEF COMPLAINT (If Accident State How, When, and Where)

TEMP.	PULSE	RESP.	B/P	ALLERGIES	MEDICATIONS - HOME	E.R. PHYSICIAN	TET. TOX.

NURSES NOTES:

NURSE'S SIGNATURE (RN OR LPN)

LAB DATA (Including X-Rays, EKGs, etc.)

PHYSICIAN'S REPORT

DIAGNOSIS:

TREATMENT:

CONDITION ON DISC: IMP | STABLE | EXPIRED

INSTRUCTIONS TO PATIENT:

FOLLOW-UP WITH M.D.

PATIENT'S SIGNATURE ON DISCHARGE
BY SIGNING HERE I CERTIFY THAT I UNDERSTAND THE FOLLOW-UP INSTRUCTIONS RECEIVED BY ME IN WRITING, WHICH WERE EXPLAINED TO ME.

DATE - TIME OF DISC.

PHYSICIAN'S SIGNATURE M.D.

E.R.

HUNN JOWEL
88813 HITCHUM O D MD
OP-01/08/77 27 MALE
05/23/04

ER/ROOM

Wiregrass Medical Center
1200 W. Maple Avenue
Geneva, Alabama 36340

CONDITIONS FOR TREATMENT

1. **MEDICAL AND SURGICAL CONSENT FOR TREATMENT:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to furnish the necessary treatment, surgical procedures, anesthesia, x-ray examinations or treatments, drugs and supplies as may be ordered or requested by the attending physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery or examinations in the hospital. The undersigned recognizes that all physicians furnishing services to the patient may be independent contractors and are not employees or agents of the Hospital.

2. **RELEASE OF INFORMATION:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to release to any insurers, their representatives or other third parties confidential information (including copies of records) relative to this hospitalization. This authorization includes, but is not limited, to the release of information relating to drug, alcohol and or psychiatric treatment as specified in Federal Regulation 42, CFR part 2. I further authorize any physician or institution that attended the patient previously to furnish medical records or information which may be requested by the Hospital or attending physicians.

3. **RELEASE FROM LIABILITY FOR VALUABLES:** I have been made aware the WIREGRASS MEDICAL CENTER provides facilities for the safe keeping of my valuables and therefore, I release the Hospital from any responsibility due to loss or damage of my clothing, money, jewelry, or other items of value that I might keep at my bedside, or that may be brought to me by my friends and relatives.

4. **GUARANTOR AGREEMENT:** The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.

5. **ASSIGNMENT OF INSURANCE BENEFITS:** In the event the undersigned and/or patient is entitled to Hospital benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to WIREGRASS MEDICAL CENTER for application to the patient's bill. It is agreed that the Hospital may receipt for any such payment and such payment will discharge the said insurance company of all obligations under the policy to the extent of such payment. The undersigned and/or patient agrees to be responsible for charges not paid by this assignment.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ OR HAD THE FOREGOING INFORMATION EXPLAINED, HAS RECEIVED A COPY, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Date 5-23- 20 04

Witness

Patient

Patient's Agent or Representative

Relationship to Patient

ASSIGNMENT OF MEDICARE BENEFITS:
PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST

"I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for Part A deductible for each spell of illness, the Part B deductible for each year, the remaining 20% of reasonable charges and any personal charges incurred."

Date | Signature | Relationship to Patient

ACKNOWLEDGEMENT OF MEDICARE

I hereby declare I am a participant in the Medicare Program and I am not enrolled in a health maintenance organization, (H.M.O.), or any other pre-paid group practice. I understand that if it is found that I am a participant in any of the above mentioned practices, I will be considered a self-pay patient required to pay in full immediately.

Date | Signature | Relationship to Patient

Rev. 9/00

WIREGRASS MEDICAL CENTER

Billing Form

For Financial Class:

P

Patient Name.....	NUNN, JOWEL	Discharge Date.....	05/23/2004
Admission Date.....	05/23/2004	Date of Birth.....	01/08/1977
Medical Record Number.....	422847896	Sex.....	Male
Age.....	27		
Account Number.....	488813		

DX	Code	DX Description
1	922.1	Contusion of Chest Wall
2	E819.2	MV Traffic Accident NOS Injuring Motorcyclist

PR	Code	PR Description	Procedure Date	Surgeon

CPT	Code	CPT Modifiers	CPT Description	CPT Date	CPT Surgeon
		APC PSI	Payment Rate	ASC Group	ASC Fee

Attending Physician..... 000700

Consulting Physician.....

Discharge Disposition..... 01 - Home

DRG =

Status.....

Memo

DRG

MDC Weight AMLOS GMLOS LOS

WIREGRASS MEDICAL CENTER

1200 WEST MAPLE AVENUE
GENEVA, ALABAMA

RADIOLOGY REPORT

NAME: NUNN JOWEL
AGE: 27 **SEX:** M
DOB: 01/08/1977
STAY TYPE: E.R. ROOM:
ADMIT DATE: 05/23/04
ACCT NUMBER: 488813
LOCATION:
TRANS DATE: 5/24/04

PATIENT PHONE: 334/898/9907
ORDERING PHY: MITCHUM O
ADMITTING PHY: MITCHUM O
REFERRING PHY:
FAMILY PHY:
XRAY NUMBER: 2604
MR NUMBER: 422847896
TRANS INITIALS: SER

<=X-RAY ORDER=> COMPLETE:05/23/04 21:52 SAD 77007
Reason for Procedure: MVA
RIBS UNILATERAL 2V 71100 COMPLETE:05/23/04 21:52 SAD 77008

*** UNSIGNED TRANSCRIPTIONS REPRESENT A PRELIMINARY REPORT AND DOES ****** NOT REFLECT A MEDICAL OR LEGAL DOCUMENT ***

LEFT RIB DETAIL: THE RIBS ARE INTACT. THERE IS NO DEFINITE FRACTURE OR OTHER ABNORMALITY NOTED.

OPINION: UNREMARKABLE EXAM.

JOHN C. TOMBERLIN, M.D.

Joel Nunn
NUNN JOWEL E.R.
38813 MITCHUM O D MD
01/08/77 27 MALE
05/23/04
Addressograph

Wiregrass Medical Center
ER Medical Record
( ) Emergent ( ) Urgent (✓) Non-Emergent

Triage Notes: BM c/o pain in (L) ribs when breathing started today. Motorcycle accident 2 days ago.	Time: 2150
	Temp: 96⁹
Tet: Wt:	Pulse: 76
Allergies: NKDA LMP: SpO2: 98%	Resp: 24
Meds: antibiotics, pain pills?	BP: 161/94
Nurse Signature: J Pettis RN	
H&P and CC:	PMH:
HPI: Hx above	Surg:
	Social/Habits:
General: Tender (L) rib cage	Family Hx:
HEENT	
Neuro: Obvious healing	ROS Neg Document if positive
Heart:	Neuro/Psych: ☐
Lungs: X-ray - see no	Cardio/Resp: ☐
Musculoskeletal:	GU: ☐
Abd/Rectal: Dx: Contusion chest	Other: ☐
GU/Gyn:	
Ext/Skin: Rx: Rib belt	
Dx:	

Physician's Orders:	CBC( )	BMP/CMP		Medication	Ini
EKG( )	ABG( )	PT/PTT( )			
UA(Rout)(Cath)	CT( )		Amylase( )		
CXR( )	Other Studies (L) ribs		US( )		
CM( )	O2( )	Foley( )	IV:		

Disposition: Home(✓) Dr. Office( ) Surgery( ) Expired( ) Adm Rm# AMA/LWBS( ) Date/Time: 5/23/04 2220

Transfer to C/O Dr. Via

Condition at Discharge/Transfer: Improved( ) Stable(✓) Deteriorated( ) Unchanged( )

Instructions to Pt: (1) Rx:

(2) Instructions:

(3) Follow up:

Signing this form denotes that I have reviewed all information on this document and I agree:

Physician's Signature: **Family Dr.** none

NUNN JOWEL E.R.
488813 MITCHUM O D MD
DOB-01/08/77 27 MALE
05/23/04

ER/ROOM

Addressograph

Wiregrass Medical Center
Emergency Department
Nursing Assessment

Mode of Arrival: ☑ Ambulatory ☐ Stretcher ☐ Ambulance ☐ Arms ☐ Other:

Accompanied By: ☐ Self ☑ Family/Friend ☐ Police ☐ Other
Immunizations up to date? ☐ Y ☐ N

Developmental Age Same as Stated Age ☐ Yes ☐ No

How do you prefer to learn? Written ☐ Verbal ☐ Combination ☐

Initial Contact Time: 2150 Allergies: NKDA
Date: 5/23/04

Treatment/PTA

None ☑ Cervical Collar ☐ Spineboard: ☐ Splint ☐ Dressings ☐ _____
IV Fluids:_____ Rate:_____ Site:_____
Airway: None ☐ Oral ☐ ET Tube ☐ ☐ Oxygen _____ via ☐ NC ☐ Mask

Nutritional Assessment

Are you on a regular diet? ☑ Y ☐ N
Have you had a recent weight loss or gain? ☐ Y ☑ N
Comments:_____

Respiratory

Respirations: ☑ Regular ☐ Irregular ☐ Shallow ☐ Deep
Breath Sounds: ☑ Bil. Clear ☐ Rhonchi ☐ Rales ☐ Wheezes
Cough: ☐ Productive ☐ Nonproductive
Sternal Retractions? ☐ Yes ☑ No
Dyspnea? ☐ Yes ☑ No
Comments:_____

Circulation

Skin: ☑ Warm ☑ Dry ☐ Hot ☐ Diaphoretic ☐ Cold ☐ Clammy
Color: ☑ Normal ☐ Pink ☐ Dusky ☐ Flushed ☐ Pale ☐ Cyanotic ☐ Jaundice
Edema: ☐ Yes ☑ No
JVD: ☐ Yes ☑ No
Capillary Refill: ☑ Quick ☐ Slow
Comments:_____

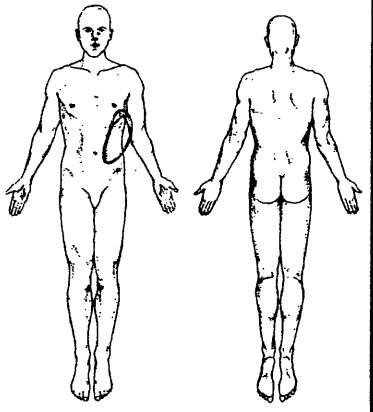
GI/Genitourinary

☐ Distended ☐ Nausea
☐ Vomiting ☐ Diarrhea
☐ Constipation ☐ LBM:_____
Bowel Sounds: ☑ Present ☐ Absent
Comments:_____

GU/GYN

Pain in Voiding: ☐ Yes ☑ No
Frequency ☐ Yes ☑ No
Bleeding: ☐ Yes ☐ No
Vaginal Bleeding ☐ Yes ☐ No
Vaginal Discharge ☐ Yes ☐ No
☐ Scant ☐ Moderate ☐ Large
Grav_____ Para_____ Ab_____
Comments:_____

Pain/Injury Location



Location (circled above)

Radiation (arrow above)

Pain Assessment

Severity:_____
0 1 2 3 4 5 6 7 8 9 10
Exacerabated By:_____
Relieved By:_____ ☐ Pt unable to rate

GI/Genitourinary

Eyes Open:	Spontaneously	4
	To Verbal Command	3
	To Pain	2
	No Response	1
Best Motor Response	Obeys	6
	Localizes Pain	5
	Flexion-Withdrawal	4
	Flexion/Abnormal (Decorticate Rigidity)	3
	Extension (Decerebrate Rigidity)	2
	No Response	1
Best Verbal Response	Oriented/Converses	5
	Disoriented/Converses	4
	Inappropriate Words	3
	Incomprehensible Sounds	2
	No Response	1

GCS Total (3-15):

Neurological

Level of Consciousness:
☑ Alert ☐ Responds to Voice ☐ Responds to Pain ☐ Unresponsive ☐ Lethargic
Orientation:
☑ Appropriate Response ☐ Inappropriate Response
Pupils: Brisk ☐ L ☐ R Sluggish ☐ L ☐ R Nonreactive ☐ L ☐ R
Size: L:_____ R:_____
Visual Acuity: ☐ N/A
OD:_____ OS:_____
Movement: ☐ Voluntary ☐ Involuntary
Hand Grasp: L R
Strong ☐ ☐
Weak ☐ ☐
Absent ☐ ☐
Slurred Speech? ☐ Yes ☑ No

Extremities

Location(s): old abrasion
Size(s):_____
Bleeding Controlled: ☐ Yes ☐ No
Comments:_____
Full Range of Motion ☐ Y ☐ N
Pulse:_____ ☐ Y ☐ N
Sensation Intact: ☐ Y ☐ N

Emotional Assessment

Eye Contact ☑ Y ☐ N
Affect: ☐ Normal ☐ Flat
☑ Cooperative ☐ Disoriented
☐ Combative ☐ Anxious

Do you feel safe in your present living environment?
☑ Yes ☐ No
If no, would you like to talk to someone? ☐ Yes ☐ No
Comments:_____

Orthopedic

Ext Deformity: ☐ Yes ☐ No
Full ROM: ☐ Yes ☐ No
Pulse:_____ NA
Cap. Refill: ☐ Brisk ☐ Slow
Temp: ☐ Warm ☐ Cold
Sensation Intact: ☐ Yes ☐ No

Signature

Pettis RN

401A

Medications

Time	Medication	Rte	Site	Init	Response

IV Fluids

Time	Type of Fluid	Cath Size	Rate	Site	Initial

Pain Assessment/Reassessment

Pain Intensity: ______ 0 1 2 3 4 5 6 7 8 9 (10 circled)
❑Pt unable to rate
Time: 2220 Location: (L) ribs
Intervention: discharged
Initials: JP

Pain Intensity: ______ 0 1 2 3 4 5 6 7 8 9 10
❑Pt unable to rate
Time: ______ Location: ______
Intervention: ______
Initials: ______

Pain Intensity: ______ 0 1 2 3 4 5 6 7 8 9 10
❑Pt unable to rate
Time: ______
Location: ______
Intervention: ______
Initials: ______

Vital Signs

Time	Temp	Pulse	RR	B/P	SaO2

Procedure/Treatment

Procedure/Treatment	Time	Ini
Cardiac Monitor		
O2 Type ______ Rate: ______		
EKG		
Xray Type:		
Location: (L) ribs	2200	JP
Dressing Type:		
Location:		
Splint Type:		
Location:		
Foley:		
N/G Tube:		
Other:		

Nurses Notes

2155 - admitted to bay #1 via w/c —JP
2210 - returned from X-ray dept. Dr. Mitchum in to eval pt. & X-ray —JP
2220 - Rib belt applied & pt discharged home c̄ inst in stable condition ambulatory c̄ friend. JP

Notified: Time: ______
❑Police ❑Med. Examiner
❑Family/Friend ❑Health Dept.
❑Other (Whom: ______)
❑Valuables given to: ______
❑Sent Home

Intake: IV		Output: NG	
PO		Urine	
Other		Other	
Total		Total	

Nurse's Signature/Title	Init
JPettis RN	JP

ER/ROOM
05/23/04
DOB-01/08/77 27 MALE
488813 MITCHUM O D MD
NUNN JOWEL
E.F

WIREGRASS MEDICAL CENTER

1200 W. MAPLE AVE.
GENEVA, AL 36340
(334) 684-3655

NUNN JOEL E.R.
DOB-01/05/77 27 MALE
05/23/04

ED-OP
HOME INSTRUCTION SHEET

1. MEDICAL RECORD NO.	2. BILLING NO.	3. A/R NO.

INFORMATION

4. CLASS	5. DATE	6. TIME	7. SRC	8. TYPE	9. SAD

10. PATIENTS LEGAL NAME (L,F,MI)	11. SEX	12. RACE	13. BIRTHDATE	14. AGE	15. HEIGHT	16. WEIGHT	17. SS	18. MS	19.
ENROOM									

20. RP	21. NOTIFY IN EMERGENCY	22. HOME TELE	23. WORK TELE	24. HOW PATIENT ARRIVED

25. C COMPLAINT 26.	27. PROC CD	28. PROCEDURE	29. LOC	30. TIME	31. ANES

OUTPATIENT SURGERY INFORMATION

32. PHYSICIAN CALLED	33. ATTENDING PHYSICIAN	34. FAMILY PHYSICIAN

SPRAIN, FRACTURE, & SEVERE BRUISES

- ☐ Elevate the injured part above level of heart to lessen swelling. If pillows flatten, use chair cushions with pillows or blanket for comfort.
- ☐ Ice packs also help prevent swelling, especially during the first 48 hours.
- ☐ Place ice in plastic or rubber bag, cloth covering; after 48 hours, use heat.
- ☐ If you have an elastic bandage, rewrap it if too tight or loose. Remove at bedtime and replace in A.M.
- ☐ If you have a cast, keep it perfectly dry at all times.
- ☐ Wiggle toes or fingers to help prevent swelling in the cast–this should be done often if it does not cause pain.
- ☐ If the part swells anyway or gets cold, blue or numb or pain increases markedly, have it checked promptly.
- ☐ Use crutches.

BACK AND NECK INJURY INSTRUCTIONS

- ☐ USE HEAT OR COLD ON THE INJURED AREA - whichever seems to help the most. Be careful not to burn yourself.
- ☐ Rest as much as possible until you are improved.
- ☐ Avoid positions and movement that make the pain worse.
- ☐ Relax emotionally - if you are tense the problem will on be worse.
- ☐ Gentle but firm massage will increase circulation in sore muscles and helps to clear the soreness.
- ☐ Wear special collar when out of bed.

HEAD INJURY INSTRUCTIONS

Persons who receive blows to the head may have injuries that cannot always be seen by X-ray or examination soon after accident. For the next 24 hours it is important that these instructions be followed:

- ☐ Awaken the patient every two hours, even at night, to be sure he knows where he is and is not confused.
- ☐ Check eyes to see that both pupils are of equal size.
- ☐ Prevent the taking of sleeping pills, tranquilizers or alcohol.
- ☐ Restrict excessive work or play.

Call your family doctor or local hospital immediately if the patient:

- ☐ Develops a severe headache.
- ☐ Vomits more than twice within a short time.
- ☐ Is confused, faints or is hard to awaken.
- ☐ Has a pupil of one eye larger that the other
- ☐ Complains of double vision
- ☐ Shows abnormal behavior such as staggering or walking into things.

X-RAY INSTRUCTIONS

Your X-rays have been read by the attending physician in the Emergency Dept. For your added protection, your X-rays will be reread the next morning by Radiology Dept. If any abnormalities are found that have not been called to your attention, you and your doctor will be called immediately. (Please be certain that the Emergency Dept. has a phone number where you can be reached.) Sometimes fractures or abnormalities may not show up on X-rays for several days. If your symptoms continue or get worse, call your doctor. More X-rays may need to be taken. If you are referred to another physician, come by the hospital and pick up your X-ray and take them with you to the doctor's office. Please call ahead to X-ray Dept.

WOUND CARE (Cuts, Abrasions, Burns, Stitches)

- ☐ Keep the dressings clean and dry.
- ☐ Elevate the wound to help relieve soreness and help speed wound healing.
- ☐ Despite the greatest care, any wound can be infected. If your wound becomes red, swollen, shows pus or red streaks, or feels more sore instead of less sore as days go by, you must report to your doctor right away.
- ☐ Dressing should be changed in _____ days.
- ☐ Treatment rendered _____.
- ☐ Tetanus Toxiod given _____. 250 units of tetanus immune globulin was given. To complete your immunization, you must receive two additional doses of toxoid 4-6 weeks apart. Call your physician for the next dose.
- ☐ Warm soaks to area 4 times daily. 20-40 minutes each time.
- ☐ Continuous warm compresses.

VOMITING & DIARRHEA

- ☐ Do not feed anything for 4 hours.
- ☐ After 4 hours, if there is not vomiting and/or diarrhea, offer 2 tablespoons (1 ounce) of any of the following: clear liquids, Coke, Gingerale, 7-up, weak tea, Gatorade or Jello, water. If patient is hungrey you may add 1 teaspoon of sugar to each ounce of liquid.
- ☐ UNDER NO CIRCUMSTANCES USE MILK OR MILK PRODUCTS.
- ☐ The 2 tablespoons of liquid may be offered every hour. If after 4 hours no vomiting has occured, the amount may be slowly increased.
- ☐ Using no more than ½ glass (4 ounces) of liquid at a time continue this treatment for 24 hours.
- ☐ Contact your doctor's office for further instructions after 24 hours.

GENERAL INSTRUCTIONS

- ☐ Stay in bed/may go to bathroom.
- ☐ Use vaporizor.
- ☐ Drink large amounts of liquids.
- ☐ Take _____ aspirin every 4 hours..
- ☐ Avoid any use of injured part.
- ☐ Allow only limited use of the part.
- ☐ You need not necessarily limit activity.
- ☐ Fill Prescriptions given to you from Emergency Dept. and take as directed.
- ☐ No driving or any activity requiring mental alertness after receiving medication.

FEVER OVER 102

- ☐ Sponge with lukewarm water in the tub.
- ☐ If temperature increases or persists for 24 hours, see your family doctor.

EYE INJURY

- ☐ Any eye injury is potentially hazardous.
- ☐ Any increasingly severe discomfort, redness or sudden impairment of vision should be reported immediately to your physician or eye specialist below.
- ☐ Do not drive with eye patch.

ANIMAL OBSERVATION

Instructions for observation of any animal that may have bitten a human if that animal is available for observation.

- ☐ Have animal taken to Vetennarian for observation.
- ☐ If the owner should refuse to take the animal to the Vetennarian, notify the County Health Officer of the situation.

ADDITIONAL INSTRUCTIONS wear sup belt till follow-up with reg. dr or pain decreases

I hereby acknowledge receipt of all the instructions indicated above. I understand that I have received EMERGENCY treatment only and that I may be released before al my medical problems are known or treated. I will arrange for follow-up care as indicated above. I understand that if my conditions worsen or new symptoms appear, I should contact my Doctor immediately.

PATIENT/PARENT'S SIGNATURE x Joel S. Nunn NURSE'S SIGNATURE Pettis RN PHYSICIAN'S SIGNATURE

SCHOOL AND WORK EXCUSE *PATIENT NAME* *DATE*

- ☐ No work for _____ days
- ☐ Light work for _____ days
- ☐ May return to work on _____
- ☐ No school for _____ days
- ☐ No Physical Education for _____ days
- ☐ May return to school on _____

WIREGRASS MEDICAL CENTER PHYSICIAN'S SIGNATURE

ADVANCE DIRECTIVE
ACKNOWLEDGEMENT

NAME: Nun Jowel SOC. SEC. NO: 422-54-7896
IDENTIFICATION NO: 488813 DATE OF BIRTH: 1-7-77

PLEASE READ THE FOLLOWING FOUR STATEMENTS.

1. I have been given written materials about my right to accept or refuse medical treatments

2. I have been informed of my rights to formulate Advance Directives.

3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility.

4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

☐ **I HAVE** executed an Advance Directive.

☒ **I HAVE NOT** executed an Advance Directive.

Signed Jowel S. Nun Date: _____

Witness: [illegible] Date: 5-23-04

Witness: _____ Date: _____

Form # 390 Advance Directive Acknowledgement

NUNN JOWEL E
4R6813 MITCHUM O D MD
DOB-01/08/77 27 MALE
05/23/04

ER/ROOM

Wiregrass Medical Center
Emergency Physician's Charge Sheet

Date:_____

Level of Service		
	19599281	Level I
	19599282	Level II
	19599283	Level III
	19599284	Level IV
	19599285	Level V
	19599288	Direct Life Support In Transit
	19599025	Visit with Surgery
	19599291	Critical Care per Hour
	19599292	Critical Care per 1/2 hour
	19591105	NG Lavage/Aspiration
	19599175	Ipecac Admin/Observe Gastric emptying
Airway/Pulmonary		
	19531500	Endotracheal Intubation
	19531511	FB Removal
	19532020	Tube Thoracostomy
Vascular Procedures		
	19536410	Non-Routine Venipuncture
	19590780	IV Therapy Requiring MD per hour
	19592977	Thrombolysis IV infusion
Cardiac Procedures		
	19592950	CPR
	19592953	Transcutaneous Pacing
	19592960	Cardioversion, Elective
Opthamology		
	19565205	FB
	19565210	FB Conjunctival/Embedded
	19567938	FB, Eyelid
Ear,Nose, and Throat		
	19542809	FB Pharynx
	19569200	FB External Ear Canal
	19569210	Impacted Cerumen
	19530300	FB Intranasal
	19530901	Anterior Epitaxis, Simple
	19530903	Anterior Epitaxis, Complex
	19530905	Posterior Epitaxis, Initial
Soft Tissue/Foreign Body Removal		
	19510120	Sub Q, Simple
	19510121	Sub Q, Complicated
	19520520	Muscle, Simple
	19520525	Muscle, Complex
Nails		
	19511730	Avulsion/Nail, Simple
	19512740	Subungal Hematoma

Debridement		
R	19511000	Infected Skin
	19511040	Partial Skin Thickness
	19511041	Skin, Full Thickness
	19511042	Skin and Sub Q Tissue
	19511043	Skin, Sub Q, Muscle
	19511044	Skin, Sub Q, Muscle, Bone
Hematoma and Abcess		
	19510060	I&D Simple Abcess, Furuncle
	19510061	I&D Simple Abcess, Complicated/ Multiple
	19510140	I&D Hematoma Simple
	19510160	I&D Puncture Aspiration, Abcess
	19546320	Hemorrhoid, Thrombosed
Burns		
	19516000	First Degree Burn, Initial
	19516020	Small Burn, Debride,Dress
	19516025	Medium Burn, Debride/Dress
	19516030	Large Burn, Debride/Dress
OB/GYN Procedures		
	19556405	I&D, Abcess, Vulva
	19556420	I&D, Bartholin Abcess
	19559410	Emergency Vaginal Delivery
Arthrocentesis		
	19520600	Arthrocentesis, Small Joint
	19520605	Arthrocentesis, Intermediate Joint
	19520610	Arthrocentesis, Major Joint
Miscellaneous Fractures		
	19521800	Closed Rib Fracture
	19523500	Clavicle
	19526750	Closed Distal Phalangeal
	19528490	Closed Fracture, Great Toe
	19528510	Closed Phalanx other than Gr. Toe
Miscellaneous Closed Dislocations		
	19521480	TMJ Uncomplicated
	19523650	Shoulder w/ Manipulation
	19524640	Nursemaid's Elbow
	19526700	Finger, MP Joint
	19526770	Finger, IP Joint
	19528660	Toe IP Joint
Miscellaneous Procedures		
	19553670	Urine Catheterization, Simple
	19553675	Urine Catheterization, Complex
	19562270	Spinal Puncture
	19564450	Digital Block
	19582270	Stool for Occult Blood
	19593042	Rhythm Strip Interpretation
Repair/Simple- Single Layer		
Scalp, Neck, Axillate, External Genitalia, Trunk, and/or extremities		
	19512001	2.5 cm or less
	19512002	2.6 - 7.5 cm
	19512004	7.6 - 12.5 cm
	19512005	12.6 - 20.0 cm
	19512006	20.1 - 30.0 cm

Repair/Simple- Single Layer Cont'd		
Face, Ears, Eyelids, Nose, Lips, and/or Mucous Membranes		
	19512011	2.5 cm or less
	19512013	2.6 - 5.0 cm
	19512014	5.1-7.5 cm
	19512015	7.6 - 12.5 cm
	19512016	12.6 - 20.0 cm
	19512017	20.1 - 30.0 cm
	19512018	Over 30.0 cm
	19512020	Superficial WD Dehis
	19512021	Superficial WD Dehis-Pack
Repair/Intermediate-Layered		
Scalp, Axillae, Trunk, and/or Extremities		
	19512031	2.5 cm or less
	19512032	2.6 - 7.5 cm
	19512034	7.6 - 12.5 cm
	19512035	12.6 - 20.0 cm
	19512036	20.1 - 30.0 cm
	19512037	Over 30.0 cm
Neck, Hand, Feet, and/or External Genitalia		
	19512041	2.5 cm or less
	19512042	2.6 - 7.5 cm
	19512044	7.6- 12.5 cm
	19512045	12.6 - 20.0 cm
	19512046	20.0 - 30.0 cm
	19512047	Over 30.0 cm
Face, Ears, Eyelids, Nose, Lips, and/or Mucous Membranes		
	19512051	2.5 cm or less
	19512052	2.6 - 5.0 cm
	19512053	5.1 - 7.5 cm
	19512054	7.6 - 12.5 cm
	19512055	12.6 - 20.0 cm
	19512056	20.1 - 30.0 cm
	19512057	Over 30.0 cm
Repair/Complex-Reconstructive or Complicated Wound Closure		
Trunk		
	19513100	1.1 - 2.5 cm
	19513101	2.6 - 7.5 cm
Scalp, Arms, and/or Legs		
	19513120	1.1 - 2.5 cm
	19513121	2.6 - 7.5 cm
Forehead, Cheeks, Chin, Mouth, Neck, Axillae, Genitalia, Hands, and or Feet		
	19513132	1.1 - 7.5 cm
Eyelids, Nose, Ears, and/or Lips		
	19513151	1.1 - 2.5 cm
	19513152	2.6 - 7.5 cm

Wiregrass Medical Center
ER Level of Service Charge Sheet

NUNN JOWEL E.R.
488813 MITCHUM O D MD
DOB-01/08/77 27 MALE
05/23/04

ER/ROOM

Circulatory		
Jugular,Cutdown, Central Line		
Blood Administration	19636430	
Cardioversion, Mechanical	19692960	
Code Blue	19692950	
External Pacemaking	19692953	
Intubation	19631500	
Immunization (Td, Hepatitis B)		
Immunization (Rabies)	19690675	
Medication Administration IV	19690784	
Medication Administration IM or SQ	19690782	
Paracentesis	19649080	
Peritoneal Lavage/Tap		
Thoracentesis	19632000	
Pericardiocentesis	19633010	
Chest Tube Insertion	19632002	
IV Hydration		
CPR		
ENT		
Eye Irrigation		
Eye Exam/Corneal Abrasion		
Foreign Body Removal Ear		
Foreign Body Removal Nose		
Irrigation Ear		
Nose Bleed/Nasal Packing		
Rust Ring (Foreign Body Removal)		
Respiratory		
Tracheotomy	19631603	
Cricothyrotomy	19631605	
Trach Change	19631603	
Gastrointestinal		
Gastric Lavage or NGT insertion	19691105	
Gastrostomy Tube Placement	19643760	
Genitourinary		
Delivery/Birth	19659409	
Supra Pubic Cath, or Turkey Tray		
Irrigation of Catheter	19651700	
Pelvic Exam		

Integumentary		
Repair of Nail Bed	19611760	
Subungal Hematoma	19611740	
Dressing Application		
FB removal	19610120	
I&D Abcess	19620000	
Laceration Repair (simple,intermed)	19600000	
Laceration Complex	19610000	
Debridement	19611040	
Treatment of Burns	19616020	
Orthopedics		
Behr Block/Regional Block		
Casting/Splinting	19629500	
Removal or Revision of Cast	19629705	
Tx of fx/dislocation with manipulation		
Compartmental Syndrome	19620950	
Neurological		
Lumbar Puncture	19662290	
Treatment Level		
Emergency WD	19699281	
Emergency I	19699282	
Emergency I with procedure		
Emergency II	19699283	✓
Emergency II with procedure		
Emergency III	19699284	
Emergency III with procedure		
Emergency IV	19699285	
Emergency IV with procedure		
Critical Care	19699291	
Critical Care with procedure		
Observation I		
Observation II		
Observation III		

6923

WIREGRASS MEDICAL CENTER 1200 W MAPLE AVE GENEVA AL 36340

EMERGENCY ROOM • OUTPATIENT RECORD

PATIENT NUMBER	TYPE	PATIENT NAME	AGE	BIRTHDATE	SEX	M/S	DATE OF SERVICE	TIME	CLERK INIT.
496952	3	NUNN JOWEL	27	1/08/1977	M	SB	9/27/04	09:29	EHS

ADDRESS - LINE 1	ADDRESS - LINE 2	CITY	STATE	ZIP CODE	TELEPHONE
202 SOUTH BROAD ST		SAMSON	AL	36477	334-898-9907

PATIENT SSAN	NOTIFY IN CASE OF EMERGENCY - NAME	RELATIONSHIP	ADDRESS	TELEPHONE
422847896	NUNN LINDA FAYE	MOTHER	SAME SAMSON AL	334-898-9907

INSURANCE COMPANY	CONTRACT OR GROUP NUMBER	DATE	PLACE	ACCIDENT
		TIME	EVENT	

GUARANTOR NAME	GUARANTOR ADDRESS	CITY	STATE	ZIP CODE	GUAR. TELEPHONE	GUARANTOR
NUNN JOWEL	202 SOUTH BROAD ST	SAMSON	AL	36477	898-9907	

GUARANTOR EMPLOYER	GUARANTOR OCCUPATION	GUAR. EMPLOYER ADDRESS	GUAR. EMPL TELEPHONE
SELF			

PREV. SERVICE	PREV. SERV. DATE	IF MINOR - PARENT NAME	MED. REC. #	ADMITTING/2ND PHYSICIAN
488813	5/23/04		422847896	MCLEOD J W/

CHARGES	X-RAY	LAB	RESP. TH.	PHY. TH.	EKG	I.V.	DRUGS	SUPPLIES	OTHER	M.D.	E.R. RM	TOTAL DUE

AUTHORIZATION FOR TREATMENT, GUARANTEE OF PAYMENT , ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned has been informed of the emergency treatment considered necessary for the above named patient, and that treatment and procedures will be performed by physicians, members of house staff and employees of the hospital. Authorization is hereby granted for such treatment and procedures. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained.
2. The undersigned agrees to pay for services rendered by Hospital upon release of patient.
3. I/we hereby assign any hospital benefits, sick benefits, injury benefits due to a liability of a Third party, payable by any party, for the above patient, to Hospital unless I pay the account in full upon release of patient.
4. I/we hereby authorize the "Administrator of Hospital" to furnish from its records any information requested by the before mentioned insurance companies in connection with the above assignment. I do hereby appoint the "Controller" of Hospital as my lawful attorney to endorse for me any checks made payable to me for benefits or claims collected under the above assignment and to apply any credit balance to any other account I may owe said hospital.

DATE TIME SIGNED PATIENT SIGNED GUARANTOR

CHIEF COMPLAINT (If Accident State How, When, and Where)

TEMP.	PULSE	RESP.	B/P	ALLERGIES	MEDICATIONS - HOME	E.R. PHYSICIAN	TET. TOX.

NURSES NOTES:

NURSE'S SIGNATURE (RN OR LPN)

LAB DATA (Including X-Rays, EKGs, etc.)

PHYSICIAN'S REPORT

DIAGNOSIS:

TREATMENT:

CONDITION ON DISC: IMP | STABLE | EXPIRED

INSTRUCTIONS TO PATIENT:

FOLLOW-UP WITH M.D.

PATIENT'S SIGNATURE ON DISCHARGE
BY SIGNING HERE I CERTIFY THAT I UNDERSTAND THE FOLLOW-UP INSTRUCTIONS RECEIVED BY ME IN WRITING, WHICH WERE EXPLAINED TO ME.

DATE - TIME OF DISC.

PHYSICIAN'S SIGNATURE M.D.

Wiregrass Medical Center
1200 W. Maple Avenue
Geneva, Alabama 36340

CONDITIONS FOR TREATMENT

Nunn, Jewel 496952

1. **MEDICAL AND SURGICAL CONSENT FOR TREATMENT:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to furnish the necessary treatment, surgical procedures, anesthesia, x-ray examinations or treatments, drugs and supplies as may be ordered or requested by the attending physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery or examinations in the hospital. The undersigned recognizes that all physicians furnishing services to the patient may be independent contractors and are not employees or agents of the Hospital.

2. **RELEASE OF INFORMATION:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to release to any insurers, their representatives or other third parties confidential information (including copies of records) relative to this hospitalization. This authorization includes, but is not limited, to the release of information relating to drug, alcohol and or psychiatric treatment as specified in Federal Regulation 42, CFR part 2. I further authorize any physician or institution that attended the patient previously to furnish medical records or information which may be requested by the Hospital or attending physicians.

3. **RELEASE FROM LIABILITY FOR VALUABLES:** I have been made aware the WIREGRASS MEDICAL CENTER provides facilities for the safe keeping of my valuables and therefore, I release the Hospital from any responsibility due to loss or damage of my clothing, money, jewelry, or other items of value that I might keep at my bedside, or that may be brought to me by my friends and relatives.

4. **GUARANTOR AGREEMENT:** The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.

5. **ASSIGNMENT OF INSURANCE BENEFITS:** In the event the undersigned and/or patient is entitled to Hospital benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to WIREGRASS MEDICAL CENTER for application to the patient's bill. It is agreed that the Hospital may receipt for any such payment and such payment will discharge the said insurance company of all obligations under the policy to the extent of such payment. The undersigned and/or patient agrees to be responsible for charges not paid by this assignment.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ OR HAD THE FOREGOING INFORMATION EXPLAINED, HAS RECEIVED A COPY, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Date 9-27-04 20____ X Jewell Nunn
Patient

Witness Ernestine Shiver

Patient's Agent or Representative

Relationship to Patient

ASSIGNMENT OF MEDICARE BENEFITS:
PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST

"I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for Part A deductible for each spell of illness, the Part B deductible for each year, the remaining 20% of reasonable charges and any personal charges incurred."

Date | Signature | Relationship to Patient

ACKNOWLEDGEMENT OF MEDICARE

I hereby declare I am a participant in the Medicare Program and I am not enrolled in a health maintenance organization, (H.M.O.), or any other pre-paid group practice. I understand that if it is found that I am a participant in any of the above mentioned practices, I will be considered a self-pay patient required to pay in full immediately.

Date | Signature | Relationship to Patient

Rev. 9/00

WIREGRASS MEDICAL CENTER

Billing Form

For Financial Class:

P

Patient Name..... NUNN, JOWEL
Admission Date..... 09/27/2004
Medical Record Number..... 422847896
Age..... 27
Account Number..... 496952

Discharge Date..... 09/27/2004
Date of Birth..... 01/08/1977
Sex..... Male

DX	Code	DX Description
1	686.9	Local Skin/Subcutaneous Infection NOS
2	214.1	Lipoma Skin/Subcutaneous Tissue NEC

PR	Code	PR Description	Procedure Date	Surgeon

CPT	Code	CPT Modifiers	CPT Description	CPT Date	CPT Surgeon
		APC PSI	Payment Rate	ASC Group	ASC Fee

Attending Physician..... 006900
Consulting Physician.....
Discharge Disposition..... 01 - Home
DRG =
Status.....

Memo
DRG

MDC Weight AMLOS GMLOS LOS

PRINT DATE: 09/30/04 903 Wiregrass Hospital PAGE 1
Ed Benak M.D. 01D0304961
Medical Director CLIA Number
TIME: 13:00 LABORATORY --- CUMULATIVE REPORT H5LACUMV

NAME.: NUNN JOWEL SEX.....: M PHY..: MCLEOD JIMMY W MD
ACCT#: 496952 AGE.....: 27 Y ADMIT: 09/27/04
ROOM.: E.R. - NO PENDING ORDERS DOB.....: 01/08/1977 MR#..: 422847896
PAT. PHONE: 3348989907

MICROBIOLOGY

--ORDERED--	--COLLECTED--	--REC'D--	--RESULTED--	--VERIFIED---
9/27/04 1013	9/27/04 1013	9/27/04 1116	9/30/04 1022	9/30/04 1022
RL	RL	NLS	PAG	PAG

CULTURE MISC. SOURCE

M I C R O B I O L O G Y R E P O R T ** FINAL **
S U M M A R Y

Antimicrobial Susceptibility and Organism Identification Report

Specimen Number : 04365 Requested : / /
Specimen Source : MISC. CULTURE Collected : 09/27/04 10:13
Ward of Isolation : WIREGRASS HOSP Received : 09/27/04 11:16
Requesting Physician : ER PHYSICIAN

Miscellaneous Tests and Comments

NO GROWTH
FINAL REPORT

Comments : rt wrist

Iso/Result	Identity	Organisms Identified Tested	Comments

* Susceptibilities, if performed, appear on the following page(s).

Tech : _____ Source : MISC. CULTURE ID # : 496952 ** FINAL **
Report Date : / / : Collected : 09/27/04 10:13

LEGEND: L-Low, H-High, C-Critical, A-Abnormal, *E*-Error

Luna. Jowel
1-8-87

NUNN JOWEL E.R.
496952 MCLEOD JIMMY W MD
DOB-01/08/77 27 MALE
09/27/04

ER/ROOM Addressograph

Wiregrass Medical Center
ER Medical Record ( ) Emergent ( ) Urgent (✓) Non-Emergent

Triage Notes: 27 yr old BM presents c/c "breaking out in bumps" x 1 month. Also c/o "cyst" on R arm
Time: 0523
Temp: 99.1
Tet: Wt: Pulse: 91
Allergies: NKA LMP: SpO2: 98 Resp: 18
Meds: none BP: 153/91
Nurse Signature:

H&P and CC: Breaking out
PMH:

HPI: 27 yo male complains of breaking out on his back — also has knot on his wrist & Elbow
Surg: —
Social/Habits: Incarcerated
Out Break of MRSA at prison

General: WD WN BM
Family Hx:

HEENT

ROS	Neg	Document if positive
Neuro/Psych:	☐	
Cardio/Resp:	☐	
GU:	☐	
Other:	☐	

Neuro:
Heart:
Lungs:
Musculoskeletal: good ROM wrist lipoma NT forearm
Abd/Rectal:
GU/Gyn:
Ext/Skin: multiple small sores - C & S done
Dx: pustules, Back; lipoma NT forearm

Physician's Orders:			Medication	Ini
EKG( )	ABG( )	PT/PTT( )		
UA(Rout)(Cath)	CT( )	Amylase( )		
CXR( )	Other Studies C & S	US( )		
CM( )	O2( )	Foley( ) IV:		

Disposition: Home(✓) Dr. Office( ) Surgery( ) Expired( ) Adm Rm# AMA/LWBS( ) Date/Time: 9-27-04
Transfer to C/O Dr. Via
Condition at Discharge/Transfer: Improved( ) Stable(✓) Deteriorated( ) Unchanged( )
Instructions to Pt: (1) Rx: Bactrim DS 1 BID #14; Bactroban oint
(2) Instructions: — Rifampicin 300mg BID
(3) Follow up: See MD in wk

Signing this form denotes that I have reviewed all information on this document and I agree:
Physician's Signature: **Family Dr.**

NUNN JOWEL E.R.
496952 MCLEOD JIMMY W MD
DOB-01/08/77 27 MALE
09/27/04

ER/ROOM

Addressograph

Emergency Department Nursing Assessment

Mode of Arrival: ☐ Ambulatory ☐ Stretcher ☐ Ambulance ☐ Arms ☐ Other:_____

Accompanied By: ☐ Self ☐ Family/Friend ☑ Police ☐ Other
Immunizations up to date? ☑ Y ☐ N

Developmental Age Same as Stated Age ☑ Yes ☐ No

How do you prefer to learn? Written ☐ Verbal ☐ Combination ☐

Initial Contact Time: 0923 Allergies: NKDA
Date: 9-27-04

Assessment

None ☑ Cervical Collar ☐ Spineboard: ☐ Splint ☐ Dressings ☐ _____
IV Fluids:_____ Rate:_____ Site:_____
Airway: None ☐ Oral ☐ ET Tube ☐ ☐ Oxygen _____ via ☐ NC ☐ Mask

Nutritional Assessment

Are you on a regular diet? ☑ Y ☐ N
Have you had a recent weight loss or gain? ☐ Y ☑ N
Comments:_____

Respiratory

Respirations: ☑ Regular ☐ Irregular ☐ Shallow ☐ Deep
Breath Sounds: ☐ Bil. Clear ☐ Rhonchi ☐ Rales ☐ Wheezes
Cough: ☐ Productive ☐ Nonproductive
Sternal Retractions? ☐ Yes ☑ No
Dyspnea? ☐ Yes ☐ No
Comments:_____

Circulatory

Skin: ☑ Warm ☐ Dry ☐ Hot ☐ Diaphoretic ☐ Cold ☐ Clammy
Color: ☑ Normal ☐ Pink ☐ Dusky ☐ Flushed ☐ Pale ☐ Cyanotic ☐ Jaundice
Edema: ☐ Yes ☐ No
JVD: ☐ Yes ☐ No
Capillary Refill: ☐ Quick ☐ Slow
Comments:_____

Neurological

Eyes Open: Spontaneously 4
To Verbal Command 3
To Pain 2
No Response 1

Best Motor Response: Obeys 6
Localizes Pain 5
Flexion-Withdrawal 4
Flexion/Abnormal (Decorticate Rigidity) 3
Extension (Decerebrate Rigidity) 2
No Response 1

Best Verbal Response: Oriented/Converses 5
Disoriented/Converses 4
Inappropriate Words 3
Incomprehensible Sounds 2
No Response 1

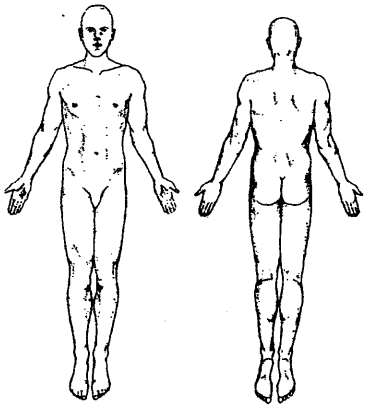
GCS Total (3-15): 15

Level of Consciousness:
☑ Alert ☐ Responds to Voice ☐ Responds to Pain ☐ Unresponsive ☐ Lethargic
Orientation:
☑ Appropriate Response ☐ Inappropriate Response
Pupils: Brisk ☐ L ☐ R
Sluggish ☐ L ☐ R
Nonreactive ☐ L ☐ R
Size: L:_____ R:_____
Visual Acuity: ☐ N/A
OD:_____ OS:_____
Movement: ☐ Voluntary ☐ Involuntary
Hand Grasp: L R
Strong ☐ ☐
Weak ☐ ☐
Absent ☐ ☐
Slurred Speech? ☐ Yes ☐ No

Abdominal

☐ Distended ☐ Nausea
☐ Vomiting ☐ Diarrhea
☐ Constipation ☐ LBM:_____
Bowel Sounds: ☐ Present ☐ Absent
Comments:_____

Pain/Injury Location



Location (circled above)

Radiation (arrow above)

Genitourinary

Pain in Voiding: ☐ Yes ☐ No
Frequency ☐ Yes ☐ No
Bleeding: ☐ Yes ☐ No
Vaginal Bleeding ☐ Yes ☐ No
Vaginal Discharge ☐ Yes ☐ No
☐ Scant ☐ Moderate ☐ Large
Grav_____ Para_____ Ab_____
Comments:_____

Trauma

Location(s):_____
Size(s):_____
Bleeding Controlled: ☐ Yes ☐ No
Comments:_____
Full Range of Motion ☐ Y ☐ N
Pulse:_____ ☐ Y ☐ N
Sensation Intact: ☐ Y ☐ N

Musculoskeletal

Ext Deformity: ☐ Yes ☐ No
Full ROM: ☐ Yes ☐ No
Pulse:_____
Cap. Refill: ☐ Brisk ☐ Slow
Temp: ☐ Warm ☐ Cold
Sensation Intact: ☐ Yes ☐ No

Psychosocial Assessment

Eye Contact ☑ Y ☐ N
Affect: ☑ Normal ☐ Flat ☐ Cooperative ☐ Disoriented ☐ Combative ☐ Anxious

Do you feel safe in your present living environment?
☑ Yes ☐ No
If no, would you like to talk to someone? ☐ Yes ☐ No
Comments:_____

Pain

Severity:_____
0 1 2 3 4 5 6 7 8 9 10
Exacerbated By:_____
Relieved By:_____ ☐ Pt unable to rate

Nurse's Signature

Medications

Time	Medication	Rte	Site	Init	Response

IV Fluids

Time	Type of Fluid	Cath Size	Rate	Site	Initial

Pain Assessment/Reassessment

Pain Intensity: ______ 0 1 2 3 4 5 6 7 8 9 10
☑Pt unable to rate
Time: [illegible] Location: ______
Intervention: ______
Initials: [illegible]

Pain Intensity: ______ 0 1 2 3 4 5 6 7 8 9 10
❑Pt unable to rate
Time: ______ Location: ______
Intervention: ______
Initials: ______

Pain Intensity: ______ 0 1 2 3 4 5 6 7 8 9 10
❑Pt unable to rate
Time: ______
Location: ______
Intervention: ______
Initials: ______

Vital Signs

Time	Temp	Pulse	RR	B/P	SaO2

Procedure/Treatment	Time	Ini
Cardiac Monitor		
O2 Type ______ Rate: ______		
EKG		
Xray Type:		
Location:		
Dressing Type:		
Location:		
Splint Type:		
Location:		
Foley:		
N/G Tube:		
Other:		

Nurses Notes

[illegible]

Notified: Time: [illegible]
❑Police ❑Med. Examiner
❑Family/Friend ❑Health Dept.
❑Other (Whom: ______)
❑Valuables given to: ______
❑Sent Home

Intake: IV		Output: NG	
PO		Urine	
Other		Other	
Total		Total	

Nurse's Signature/Title	Init
[signature]	[illegible]

WIREGRASS MEDICAL CENTER

1200 W. MAPLE AVE.
GENEVA, AL 36340
(334) 684-3655

ED-OP
HOME INSTRUCTION SHEET

1. MEDICAL RECORD NO.	2. BILLING NO.	3. A/R NO.

INFORMATION

4. CLASS	5. DATE	6. TIME	7. SRC	8. TYPE	9. SAD

10. PATIENTS LEGAL NAME (L,F,MI)	11. SEX	12. RACE	13. BIRTHDATE	14. AGE	15. HEIGHT	16. WEIGHT	17. SS	18. MS	19.

20. RP	21. NOTIFY IN EMERGENCY	22. HOME TELE	23. WORK TELE	24. HOW PATIENT ARRIVED
	NUNN JOWEL E.R.			

25. C COMPLAINT 26. 49 6952 MCLEOD JIMMY W MD
DOB-01/08/77 27 MALE

OUTPATIENT SURGERY INFORMATION

27. PROC CD	28. PROCEDURE	29. LOC	30. TIME	31. ANES

32. PHYSICIAN CALLED	33. ATTENDING PHYSICIAN	34. FAMILY PHYSICIAN
09/27/04 ER/ROOM		

SPRAIN, FRACTURE, & SEVERE BRUISES

- ☐ Elevate the injured part above level of heart to lessen swelling. If pillows flatten, use chair cushions with pillows or blanket for comfort.
- ☐ Ice packs also help prevent swelling, especially during the first 48 hours.
- ☐ Place ice in plastic or rubber bag, cloth covering; after 48 hours, use heat.
- ☐ If you have an elastic bandage, rewrap it if too tight or loose. Remove at bedtime and replace in A.M.
- ☐ If you have a cast, keep it perfectly dry at all times.
- ☐ Wiggle toes or fingers to help prevent swelling in the cast–this should be done often if it does not cause pain.
- ☐ If the part swells anyway or gets cold, blue or numb or pain increases markedly, have it checked promptly.
- ☐ Use crutches.

BACK AND NECK INJURY INSTRUCTIONS

- ☐ USE HEAT OR COLD ON THE INJURED AREA - whichever seems to help the most. Be careful not to burn yourself.
- ☐ Rest as much as possible until you are improved.
- ☐ Avoid positions and movement that make the pain worse.
- ☐ Relax emotionally - if you are tense the problem will on be worse.
- ☐ Gentle but firm massage will increase circulation in sore muscles and helps to clear the soreness.
- ☐ Wear special collar when out of bed.

HEAD INJURY INSTRUCTIONS

Persons who receive blows to the head may have injuries that cannot always be seen by X-ray or examination soon after accident. For the next 24 hours it is important that these instructions be followed:

- ☐ Awaken the patient every two hours, even at night, to be sure he knows where he is and is not confused.
- ☐ Check eyes to see that both pupils are of equal size.
- ☐ Prevent the taking of sleeping pills, tranquilizers or alcohol.
- ☐ Restrict excessive work or play.

Call your family doctor or local hospital immediately if the patient:

- ☐ Develops a severe headache.
- ☐ Vomits more than twice within a short time.
- ☐ Is confused, faints or is hard to awaken.
- ☐ Has a pupil of one eye larger that the other
- ☐ Complains of double vision
- ☐ Shows abnormal behavior such as staggering or walking into things.

X-RAY INSTRUCTIONS

Your X-rays have been read by the attending physician in the Emergency Dept. For your added protection, your X-rays will be reread the next morning by Radiology Dept. If any abnormalities are found that have not been called to your attention, you and your doctor will be called immediately. (Please be certain that the Emergency Dept. has a phone number where you can be reached.) Sometimes fractures or abnormalities may not show up on X-rays for several days. If your symptoms continue or get worse, call your doctor. More X-rays may need to be taken. If you are referred to another physician, come by the hospital and pick up your X-ray and take them with you to the doctor's office. Please call ahead to X-ray Dept.

WOUND CARE (Cuts, Abrasions, Burns, Stitches)

- ☐ Keep the dressings clean and dry.
- ☐ Elevate the wound to help relieve soreness and help speed wound healing.
- ☐ Despite the greatest care, any wound can be infected. If your wound becomes red, swollen, shows pus or red streaks, or feels more sore instead of less sore as days go by, you must report to your doctor right away.
- ☐ Dressing should be changed in _____ days.
- ☐ Treatment rendered _____.
- ☐ Tetanus Toxiod given _____. 250 units of tetanus immune globulin was given. To complete your immunization, you must receive two additional doses of toxoid 4-6 weeks apart. Call your physician for the next dose.
- ☐ Warm soaks to area 4 times daily. 20-40 minutes each time.
- ☐ Continuous warm compresses.

VOMITING & DIARRHEA

- ☐ Do not feed anything for 4 hours.
- ☐ After 4 hours, if there is not vomiting and/or diarrhea, offer 2 tablespoons (1 ounce) of any of the following: clear liquids, Coke, Gingerale, 7-up, weak tea, Gatorade or Jello, water. If patient is hungrey you may add 1 teaspoon of sugar to each ounce of liquid.
- ☐ UNDER NO CIRCUMSTANCES USE MILK OR MILK PRODUCTS.
- ☐ The 2 tablespoons of liquid may be offered every hour. If after 4 hours no vomiting has occured, the amount may be slowly increased.
- ☐ Using no more than ½ glass (4 ounces) of liquid at a time continue this treatment for 24 hours.
- ☐ Contact your doctor's office for further instructions after 24 hours.

GENERAL INSTRUCTIONS

- ☐ Stay in bed/may go to bathroom.
- ☐ Use vaporizor.
- ☐ Drink large amounts of liquids.
- ☐ Take _____ aspirin every 4 hours..
- ☐ Avoid any use of injured part.
- ☐ Allow only limited use of the part.
- ☐ You need not necessarily limit activity.
- ☑ Fill Prescriptions given to you from Emergency Dept. and take as directed.
- ☐ No driving or any activity requiring mental alertness after receiving medication.

FEVER OVER 102

- ☐ Sponge with lukewarm water in the tub.
- ☐ If temperature increases or persists for 24 hours, see your family doctor.

EYE INJURY

- ☐ Any eye injury is potentially hazardous.
- ☐ Any increasingly severe discomfort, redness or sudden impairment of vision should be reported immediately to your physician or eye specialist below.
- ☐ Do not drive with eye patch.

ANIMAL OBSERVATION

Instructions for observation of any animal that may have bitten a human if that animal is available for observation.

- ☐ Have animal taken to Vetennarian for observation.
- ☐ If the owner should refuse to take the animal to the Vetennarian, notify the County Health Officer of the situation.

ADDITIONAL INSTRUCTIONS Follow up with us in one week

I hereby acknowledge receipt of all the instructions indicated above. I understand that I have received EMERGENCY treatment only and that I may be released before al my medical problems are known or treated. I will arrange for follow-up care as indicated above. I understand that if my conditions worsen or new symptoms appear, I should contact my Doctor immediately.

PATIENT/PARENT'S SIGNATURE Jowel Nunn NURSE'S SIGNATURE PHYSICIAN'S SIGNATURE

SCHOOL AND WORK EXCUSE *PATIENT NAME* *DATE*

- ☐ No work for _____ days
- ☐ Light work for _____ days
- ☐ May return to work on _____
- ☐ No school for _____ days
- ☐ No Physical Education for _____ days
- ☐ May return to school on _____

WIREGRASS MEDICAL CENTER PHYSICIAN'S SIGNATURE

ADVANCE DIRECTIVE
ACKNOWLEDGEMENT

NAME: Nunn Jowel SOC. SEC. NO: 422847896

IDENTIFICATION NO: 496952 DATE OF BIRTH: 1-08-1977

PLEASE READ THE FOLLOWING FOUR STATEMENTS.

1. I have been given written materials about my right to accept or refuse medical treatments

2. I have been informed of my rights to formulate Advance Directives.

3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility.

4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

☐ **I HAVE** executed an Advance Directive.

☒ **I HAVE NOT** executed an Advance Directive.

Signed: JSN Date: 9-27-04

Witness: _____ Date: _____

Witness: Ernestine Shuler Date: 9-27-04

Wiregrass Medical Center
Emergency Physician's Charge Sheet

Date:

NUNN JOWEL
496952 MCLEOD JIMMY W MD
DOB-01/08/77 27 MALE
09/27/04

ER/ROOM

Level of Service		
	19599281	Level I
	19599282	Level II
	19599283	Level III
	19599284	Level IV
	19599285	Level V
	19599288	Direct Life Support In Transit
	19599025	Visit with Surgery
	19599291	Critical Care per Hour
	19599292	Critical Care per 1/2 hour
	19591105	NG Lavage/Aspiration
	19599175	Ipecac Admin/Observe Gastric emptying
Airway/Pulmonary		
	19531500	Endotracheal Intubation
	19531511	FB Removal
	19532020	Tube Thoracostomy
Vascular Procedures		
	19536410	Non-Routine Venipuncture
	19590780	IV Therapy Requiring MD per hour
	19592977	Thrombolysis IV infusion
Cardiac Procedures		
	19592950	CPR
	19592953	Transcutaneous Pacing
	19592960	Cardioversion, Elective
	19593010	EKG Interpretation
Ophthalmology		
	19565205	FB
	19565210	FB Conjunctival/Embedded
	19567938	FB, Eyelid
Ear,Nose, and Throat		
	19542809	FB Pharynx
	19569200	FB External Ear Canal
	19569210	Impacted Cerumen
	19530300	FB Intranasal
	19530901	Anterior Epitaxis, Simple
	19530903	Anterior Epitaxis, Complex
	19530905	Posterior Epitaxis, Initial
Soft Tissue/Foreign Body Removal		
	19510120	Sub Q, Simple
	19510121	Sub Q, Complicated
	19520520	Muscle, Simple
	19520525	Muscle, Complex
Nails		
	19511730	Avulsion/Nail, Simple
	19512740	Subungal Hematoma

Debridement		
	19511000	Infected Skin
	19511040	Partial Skin Thickness
	19511041	Skin, Full Thickness
	19511042	Skin and Sub Q Tissue
	19511043	Skin, Sub Q, Muscle
	19511044	Skin, Sub Q, Muscle, Bone
Hematoma and Abcess		
	19510060	I&D Simple Abcess, Furuncle
	19510061	I&D Simple Abcess, Complicated/ Multiple
	19510140	I&D Hematoma Simple
	19510160	I&D Puncture Aspiration, Abcess
	19546320	Hemorrhoid, Thrombosed
Burns		
	19516000	First Degree Burn, Initial
	19516020	Small Burn, Debride,Dress
	19516025	Medium Burn, Debride/Dress
	19516030	Large Burn, Debride/Dress
OB/GYN Procedures		
	19556405	I&D, Abcess, Vulva
	19556420	I&D, Bartholin Abcess
	19559410	Emergency Vaginal Delivery
Arthrocentesis		
	19520600	Arthrocentesis, Small Joint
	19520605	Arthrocentesis, Intermediate Joint
	19520610	Arthrocentesis, Major Joint
Miscellaneous Fractures		
	19521800	Closed Rib Fracture
	19523500	Clavicle
	19523720	Closed Phalangeal Shaft
	19526750	Closed Distal Phalangeal
	19528490	Closed Fracture, Great Toe
	19528510	Closed Phalanx other than Gr. Toe
Miscellaneous Closed Dislocations		
	19521480	TMJ Uncomplicated
	19523650	Shoulder w/ Manipulation
	19524640	Nursemaid's Elbow
	19526700	Finger, MP Joint
	19526770	Finger, IP Joint
	19528660	Toe IP Joint
Miscellaneous Procedures		
	19553670	Urine Catheterization, Simple
	19553675	Urine Catheterization, Complex
	19562270	Spinal Puncture
	19564450	Digital Block
	19582270	Stool for Occult Blood
	19593042	Rhythm Strip Interpretation
Repair/Simple- Single Layer		
Scalp, Neck, Axillae, External Genitalia, Trunk, and/or extremities		
	19512001	2.5 cm or less
	19512002	2.6 - 7.5 cm
	19512004	7.6 - 12.5 cm
	19512005	12.6 - 20.0 cm
	19512006	20.1 - 30.0 cm
	19512007	Over 30.0 cm

Repair/Simple- Single Layer Cont'd		
Face, Ears, Eyelids, Nose, Lips, and/or Mucous Membranes		
	19512011	2.5 cm or less
	19512013	2.6 - 5.0 cm
	19513014	5.1-7.5 cm
	19512015	7.6 - 12.5 cm
	19512016	12.6 - 20.0 cm
	19512017	20.1 - 30.0 cm
	19512018	Over 30.0 cm
	19512020	Superficial WD Dehis
	19512021	Superficial WD Dehis-Pack
Repair/Intermediate Layered		
Scalp, Axillae, Trunk, and/or Extremities		
	19512031	2.5 cm or less
	19512032	2.6 - 7.5 cm
	19512034	7.6 - 12.5 cm
	19512035	12.6 - 20.0 cm
	19512036	20.1 - 30.0 cm
	19512037	Over 30.0 cm
Neck, Hand, Feet, and/or External Genitalia		
	19512041	2.5 cm or less
	19512042	2.6 - 7.5 cm
	19512044	7.6- 12.5 cm
	19512045	12.6 - 20.0 cm
	19512046	20.0 - 30.0 cm
	19512047	Over 30.0 cm
Face, Ears, Eyelids, Nose, Lips, and/or Mucous Membranes		
	19512051	2.5 cm or less
	19512052	2.6 - 5.0 cm
	19512053	5.1 - 7.5 cm
	19512054	7.6 - 12.5 cm
	19512055	12.6 - 20.0 cm
	19512056	20.1 - 30.0 cm
	19512057	Over 30.0 cm
Repair/Complex-Reconstructive or Complicated Wound Closure		
Trunk		
	19513100	1.1 - 2.5 cm
	19513101	2.6 - 7.5 cm
Scalp, Arms, and/or Legs		
	19513120	1.1 - 2.5 cm
	19513121	2.6 - 7.5 cm
Forehead, Cheeks, Chin, Mouth, Neck, Axillae, Genitalia, Hands, and or Feet		
	19513132	1.1 - 7.5 cm
Eyelids, Nose, Ears, and/or Lips		
	19513151	1.1 - 2.5 cm
	19513152	2.6 - 7.5 cm

NUNN JOWEL E.R
496952 MCLEOD JIMMY W MD
DOB-01/08/77 27 MALE
09/27/04

ER/ROOM

Wiregrass Medical Center
ER Level of Service Charge Sheet

		Circulatory
		Jugular,Cutdown, Central Line
	19636430	Blood Administration
	19692960	Cardioversion, Mechanical
	19692950	Code Blue
	19692953	External Pacemaking
	19631500	Intubation
	19690471	Vacine Admin. (other than Rabies)
	19690675	Vacine Administration (Rabies)
	19690784	Medication Administration IV
	19690782	Medication Administration IM or SQ
	19690780	IV infusion-up to 1 hour
	19690781	IV infusion-each additional hour
	19649080	Paracentesis
		Peritoneal Lavage/Tap
	19632000	Thoracentesis
	19633010	Pericardiocentesis
	19632002	Chest Tube Insertion
		IV Hydration
		ENT
		Eye Irrigation
		Eye Exam/Corneal Abrasion
		Foreign Body Removal Ear
		Foreign Body Removal Nose
		Irrigation Ear
		Nose Bleed/Nasal Packing
		Rust Ring (Foreign Body Removal)
		Respiratory
	19631603	Tracheotomy
	19631605	Cricothyrotomy
	19631603	Trach Change
		Gastrointestinal
	19691105	Gastric Lavage or NGT insertion
	19643760	Gastrostomy Tube Placement
		Genitourinary
	19659409	Delivery/Birth
		Supra Pubic Cath, or Turkey Tray
	19651700	Irrigation of Catheter
		Pelvic Exam

		Integumentary
	19611760	Repair of Nail Bed
	19611740	Subungal Hematoma
		Dressing Application
	19610120	FB removal
	19620000	I&D Abcess
	19600000	Laceration Repair (simple,intermed)
	19610000	Laceration Complex
	19611040	Debridement
	19616020	Treatment of Burns
		Orthopedics
		Behr Block/Regional Block
	19629500	Casting/Splinting
	19629705	Removal or Revision of Cast
		Tx of fx/dislocation with manipulation
	19620950	Compartmental Syndrome
		Neurological
	19662290	Lumbar Puncture
		Other
	19682962	Glucose fingerstick
		Treatment Level
	19699281	Emergency WD
	~~19699282~~	~~Emergency I~~
		Emergency I with procedure
	19699283	Emergency II
		Emergency II with procedure
	19699284	Emergency III
		Emergency III with procedure
	19699285	Emergency IV
		Emergency IV with procedure
	19699291	Critical Care
		Critical Care with procedure
		Observation I
		Observation II
		Observation III

WIREGRASS MEDICAL CENTER 1200 W MAPLE AVE GENEVA AL 36340

EMERGENCY ROOM • OUTPATIENT RECORD

PATIENT NUMBER	TYPE	PATIENT NAME	AGE	BIRTHDATE	SEX	M/S	DATE OF SERVICE	TIME	CLERK INIT.
513688	3	NUNN JOWEL	28	1/08/1977	M	SB	6/04/05	16:45	JLS

ADDRESS - LINE 1	ADDRESS - LINE 2	CITY	STATE	ZIP CODE	TELEPHONE
202 SOUTH BROAD ST		SAMSON	AL	36477	334-898-9907

PATIENT SSAN	NOTIFY IN CASE OF EMERGENCY - NAME	RELATIONSHIP	ADDRESS	TELEPHONE
422847896	NUNN LINDA FAYE	MOTHER	SAME SAMSON AL	334-898-9907

INSURANCE COMPANY	CONTRACT OR GROUP NUMBER	DATE	PLACE	ACCIDENT
		TIME	EVENT	

GUARANTOR NAME	GUARANTOR ADDRESS	CITY	STATE	ZIP CODE	GUAR. TELEPHONE	GUARANTOR
NUNN JOWEL	202 SOUTH BROAD ST	SAMSON	AL	36477	898-9907	

GUARANTOR EMPLOYER	GUARANTOR OCCUPATION	GUAR. EMPLOYER ADDRESS	GUAR. EMPL TELEPHONE
SELF		COUNTY JAIL	

PREV. SERVICE	PREV. SERV. DATE	IF MINOR - PARENT NAME	MED. REC. #	ADMITTING/2ND PHYSICIAN
496952	9/27/04		422847896	KRAFT KURT/MITCHUM O

CHARGES	X-RAY	LAB	RESP. TH.	PHY. TH.	EKG	I.V.	DRUGS	SUPPLIES	OTHER	M.D.	E.R. RM	TOTAL DUE

AUTHORIZATION FOR TREATMENT, GUARANTEE OF PAYMENT , ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned has been informed of the emergency treatment considered necessary for the above named patient, and that treatment and procedures will be performed by physicians, members of house staff and employees of the hospital. Authorization is hereby granted for such treatment and procedures. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained.
2. The undersigned agrees to pay for services rendered by Hospital upon release of patient.
3. I/we hereby assign any hospital benefits, sick benefits, injury benefits due to a liability of a Third party, payable by any party, for the above patient, to Hospital unless I pay the account in full upon release of patient.
4. I/we hereby authorize the "Administrator of Hospital" to furnish from its records any information requested by the before mentioned insurance companies in connection with the above assignment. I do hereby appoint the "Controller" of Hospital as my lawful attorney to endorse for me any checks made payable to me for benefits or claims collected under the above assignment and to apply any credit balance to any other account I may owe said hospital.

DATE TIME SIGNED PATIENT SIGNED GUARANTOR

CHIEF COMPLAINT (If Accident State How, When, and Where)
SPIDER BITE

TEMP.	PULSE	RESP.	B/P	ALLERGIES	MEDICATIONS - HOME	E.R. PHYSICIAN	TET. TOX.

NURSES NOTES:

NURSE'S SIGNATURE (RN OR LPN)

LAB DATA (Including X-Rays, EKGs, etc.)

PHYSICIAN'S REPORT

DIAGNOSIS:

TREATMENT:

CONDITION ON DISC: IMP | STABLE | EXPIRED

INSTRUCTIONS TO PATIENT:

FOLLOW-UP WITH

M.D.

M.D.

PATIENT'S SIGNATURE ON DISCHARGE
BY SIGNING HERE I CERTIFY THAT I UNDERSTAND THE FOLLOW-UP INSTRUCTIONS RECEIVED BY ME IN WRITING, WHICH WERE EXPLAINED TO ME.

DATE - TIME OF DISC.

PHYSICIAN'S SIGNATURE

NUNN JOWEL E.R.
513688 KRAFT KURT D
DOB-01/08/77 28 MALE
06/04/05

ER/ROOM

Wiregrass Medical Center
1200 W. Maple Avenue
Geneva, Alabama 36340

CONDITIONS FOR TREATMENT

1. **MEDICAL AND SURGICAL CONSENT FOR TREATMENT:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to furnish the necessary treatment, surgical procedures, anesthesia, x-ray examinations or treatments, drugs and supplies as may be ordered or requested by the attending physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery or examinations in the hospital. The undersigned recognizes that all physicians furnishing services to the patient may be independent contractors and are not employees or agents of the Hospital.

2. **RELEASE OF INFORMATION:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to release to any insurers, their representatives or other third parties confidential information (including copies of records) relative to this hospitalization. This authorization includes, but is not limited, to the release of information relating to drug, alcohol and or psychiatric treatment as specified in Federal Regulation 42, CFR part 2. I further authorize any physician or institution that attended the patient previously to furnish medical records or information which may be requested by the Hospital or attending physicians.

3. **RELEASE FROM LIABILITY FOR VALUABLES:** I have been made aware the WIREGRASS MEDICAL CENTER provides facilities for the safe keeping of my valuables and therefore, I release the Hospital from any responsibility due to loss or damage of my clothing, money, jewelry, or other items of value that I might keep at my bedside, or that may be brought to me by my friends and relatives.

4. **GUARANTOR AGREEMENT:** The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.

5. **ASSIGNMENT OF INSURANCE BENEFITS:** In the event the undersigned and/or patient is entitled to Hospital benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to WIREGRASS MEDICAL CENTER for application to the patient's bill. It is agreed that the Hospital may receipt for any such payment and such payment will discharge the said insurance company of all obligations under the policy to the extent of such payment. The undersigned and/or patient agrees to be responsible for charges not paid by this assignment.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ OR HAD THE FOREGOING INFORMATION EXPLAINED, HAS RECEIVED A COPY, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Date 6-4 20 05 X Jowel S. Nunn
Patient

Witness Jamie Spann

Patient's Agent or Representative

Relationship to Patient

ASSIGNMENT OF MEDICARE BENEFITS:
PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST

"I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for Part A deductible for each spell of illness, the Part B deductible for each year, the remaining 20% of reasonable charges and any personal charges incurred."

Date Signature Relationship to Patient

ACKNOWLEDGEMENT OF MEDICARE

I hereby declare I am a participant in the Medicare Program and I am not enrolled in a health maintenance organization, (H.M.O.), or any other pre-paid group practice. I understand that if it is found that I am a participant in any of the above mentioned practices, I will be considered a self-pay patient required to pay in full immediately.

Date Signature Relationship to Patient

WIREGRASS MEDICAL CENTER

Billing Form

For Financial Class:

P

Patient Name..... NUNN, JOWEL
Admission Date..... 06/04/2005
Medical Record Number..... 422847896
Age..... 28
Account Number..... 513688

Discharge Date..... 06/04/2005
Date of Birth..... 01/08/1977
Sex..... Male

DX	Code	DX Description
1	682.3	Cellulitis/Abscess of Upper Arm/Forearm

PR	Code	PR Description	Procedure Date	Surgeon

CPT	Code	CPT Modifiers	CPT Description	CPT Date	CPT Surgeon
		APC PSI	Payment Rate	ASC Group	ASC Fee

Attending Physician..... 001600
Consulting Physician.....
Discharge Disposition..... 01 - Home
DRG =
Status.....

Memo
DRG

MDC	Weight	AMLOS	GMLOS	LOS

Wiregrass Medical Center
1200 W. Maple Ave
Geneva, AL 36340-1642
LABORATORY --- CUMULATIVE REPORT

01D0304961
CLIA Number
H5LACUMV

NAME.: NUNN JOWEL
ACCT#: 513688
ROOM.: E.R. - NO PENDING ORDERS

SEX.....: M
AGE.....: 28 Y
DOB.....: 01/08/1977
PAT. PHONE: 3348989907

PHY..: KRAFT KURT D
ADMIT: 06/04/05
MR#..: 422847896

MICROBIOLOGY

--ORDERED--	--COLLECTED--	--REC'D--	--RESULTED--	--VERIFIED---
6/04/05 1724	6/04/05 1724	6/04/05 2157	6/07/05 1058	6/07/05 1058
CGB	TB	DD	LJL	LJL

CULTURE MISC. SOURCE

SPECIFIC SITE: L ARM WOUND

M I C R O B I O L O G Y R E P O R T ** FINAL **

Antimicrobial Susceptibility and Organism Identification Report

Specimen Number : 50707
Specimen Source : MISC. CULTURE
Ward of Isolation : NURSING EMERGENCY ROOM
Requesting Physician : KURT D. KRAFT

Requested : 06/04/05
Collected : 06/04/05 17:24
Received : / / 00:00

Patient/Specimen Tests and Comments

Specimen Comments
HEAVY GROWTH ISO#1
COAGULASE POSITIVE STAPH

Organisms Identified

* 01	Staphylococcus aureus	06/07/05

Comments
This S. aureus does not demonstrate inducible clin
damycin resistance in vitro.

M I C R O B I O L O G Y R E P O R T ** FINAL **
Antimicrobial Susceptibility and Organism Identification Report

Isolate 01 Staphylococcus aureus

DRUG	Staphylococcus aureus MIC	Interp
Amp/Sulbactam	<=8/4	S
Ampicillin	2	BLAC
Amox/K Clav	<=4/2	S
Azithromycin	4	I
Chloramphenicol	<=8	S
Ceftriaxone	<=8	S
Clindamycin	<=0.5	S
Cefotaxime	<=8	S
Cefazolin	<=8	S
Ciprofloxacin	<=1	S
Erythromycin	4	I
Gatifloxacin	<=2	S
Gentamicin	<=4	S
Imipenem	<=4	S
Levofloxacin	<=2	S

LEGEND: L-Low, H-High, C-Critical, A-Abnormal, *E*-Error

NAME.: NUNN JOWEL
ACCT#: 513688
ROOM.: E.R. - NO PENDING ORDERS

SEX.....: M
AGE.....: 28 Y
DOB.....: 01/08/1977
PAT. PHONE: 3348989907

PHY..: KRAFT KURT D
ADMIT: 06/04/05
MR#..: 422847896

MICROBIOLOGY

Linezolid	<=2	S
Moxifloxacin	<=2	S
Oxacillin	<=0.25	S
Penicillin	8	BLAC
Pip/Tazo	<=4	S
Rifampin	<=1	S
Trimeth/Sulfa	<=2/38	S
Tetracycline	<=4	S
Vancomycin	<=2	S
		B-Lactamase Positive

S = Susceptible
I = Intermediate
R = Resistant

CC = Cost Code
MIC = mcg/ml (mg/L)

N/R = Not Reported
--- = Not Tested
Blank= Data not available, or drug not advisable or tested

BLac = Beta Lactamase Positive
TFG = Thymidine-dependent Strain

For Blood and CSF Isolates, a Beta-Lactamase test is recommended for Enterococus species.
IB appears in place of S, I (S), +, ++, or +++ with species known to possess inducible B-lactamases; potentially they may become resistant to all B-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined B-lactam drugs.
(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime Axetil (PO) use <8=S, 8-16=I, >16=R.
(c) For streptococci (including enterococci), Micrococcus species, and Listeria species, refer to the Ampicillin interpretation. If Ampicillin results are unavailable, refer to Penicillin. If Pen result is resistant, test Ampicillin using an alternate method.

Interpretations based on NCCLS M7-A3. Pip/Tazo for streptococci and enterococci based on manufacturer's breakpoints.

Tech : _____
Report Date : / / :

Source : MISC. CULTURE
Collected : 06/04/05 17:24

ID # : 513688

** FINAL **

LEGEND: L-Low, H-High, C-Critical, A-Abnormal, *E*-Error

NUNN JOWEL E.R.
513688 KRAFT KURT D
DOE-01/08/77 28 MALE
06/04/05

Jowel Nunn

Addressograph

Wiregrass Medical Center
ER Medical Record

( ) Emergent ( ) Urgent (✓) Non-Emergent

Triage Notes: 28 yo male c/o lesion on left arm x 4-5 days		Time:	1636
		Temp:	100.0
Tet:	Wt: 230	Pulse:	122
Allergies: NKA	LMP: SpO2: 98%	Resp:	20
Meds: none		BP:	140/105
	Nurse Signature: TBradley		
H&P and CC: Cellulitis (L) arm	PMH: Asthma, Hay Fever		
HPI: Pt c/ lesion (L) arm	Surg: hernia		
Social/Habits: ⊖ tob. ⊖ ETOH			
General: A&O NAD	Family Hx: CA		
HEENT			
Neuro:	ROS	Neg	Document if positive
Heart: RRR	Neuro/Psych:	☐	
Lungs: CTA B	Cardio/Resp:	☐	
Musculoskeletal:	GU:	☐	
Abd/Rectal:	Other:	☐	
GU/Gyn:			
Ext/Skin:			
Dx: Cellulitis (L) arm			

Physician's Orders:	CBC( )	BMP/CMP		Medication	Ini
EKG( )	ABG( )	PT/PTT( )		Rocephin 1gm	TB
UA(Rout)(Cath)		CT( )	Amylase( )		
CXR( )	Other Studies Wound C&S		US( )		
CM( )	O2( )	Foley( )	IV:		

Disposition: Home(✓) Dr. Office( ) Surgery( ) Expired( ) Adm Rm# AMA/LWBS( ) Date/Time: 06/04/05 1735

Transfer to C/O Dr. Via

Condition at Discharge/Transfer: Improved( ) Stable(✓) Deteriorated( ) Unchanged( )

Instructions to Pt: (1) Rx: Bactrim DS #30

(2) Instructions:

(3) Follow up: PMD

Signing this form denotes that I have reviewed all information on this document and I agree:

Physician's Signature: **Family Dr.** Mitchum

Date	06/04	06/04								
Time	16:32	17:19								
NiBP Systolic	148	149								
NiBP Diastolic	105	98								
NiBP Mean	119	110								
HR Avg	---	---								
VPC	---	---								
ST(II)	---	---								
SpO2	97	95								
SpO2/PR	104	110								
Imp/RR	---	---								

NUNN JOWEL E.R.
513688 KRAFT KURT D
DOB-01/08/77 28 MALE
06/04/05
ER/ROOM

NUNN JOMEL E.R.
513688 KRAFT KURT D
DOB-01/08/77 28 MALE
06/04/05

ER/ROOM

Addressograph

Wiregrass Medical Center
Emergency Department
Nursing Assessment

Mode of Arrival: ☑ Ambulatory ☐ Stretcher ☐ Ambulance ☐ Arms ☐ Other:

Accompanied By: ☐ Self ☐ Family/Friend ☑ Police ☐ Other

Immunizations up to date? ☐ Y ☐ N

Developmental Age Same as Stated Age ☐ Yes ☐ No

How do you prefer to learn? Written ☐ Verbal ☐ Combination ☑

Initial Contact Time: 1636 Allergies: NKDA

Date:

Treatment PTA

None ☑ Cervical Collar ☐ Spineboard: ☐ Splint ☐ Dressings ☐

IV Fluids: Rate: Site:

Airway: None ☑ Oral ☐ ET Tube ☐ ☐ Oxygen ____ via ☐ NC ☐ Mask

Nutritional Assessment

Are you on a regular diet? ☑ Y ☐ N

Have you had a recent weight loss or gain? ☐ Y ☑ N

Comments:

Respiratory

Respirations: ☑ Regular ☐ Irregular ☐ Shallow ☐ Deep

Breath Sounds: ☑ Bil. Clear ☐ Rhonchi ☐ Rales ☐ Wheezes

Cough: ☐ Productive ☐ Nonproductive

Sternal Retractions? ☐ Yes ☑ No

Dyspnea? ☐ Yes ☑ No

Comments:

Circulation

Skin: ☑ Warm ☑ Dry ☐ Hot ☐ Diaphoretic ☐ Cold ☐ Clammy

Color: ☑ Normal ☐ Pink ☐ Dusky ☐ Flushed ☐ Pale ☐ Cyanotic ☐ Jaundice

Edema: ☐ Yes ☑ No

JVD: ☐ Yes ☑ No

Capillary Refill: ☑ Quick ☐ Slow

Comments:

Glasgow Coma Scale

Eyes Open: Spontaneously (4); To Verbal Command 3; To Pain 2; No Response 1

Best Motor Response: Obeys (6); Localizes Pain 5; Flexion-Withdrawal 4; Flexion/Abnormal (Decorticate Rigidity) 3; Extension (Decerebrate Rigidity) 2; No Response 1

Best Verbal Response: Oriented/Converses (5); Disoriented/Converses 4; Inappropriate Words 3; Incomprehensible Sounds 2; No Response 1

GCS Total (3-15): 15

Neurological

Level of Consciousness: ☑ Alert ☐ Responds to Voice ☐ Responds to Pain ☐ Unresponsive ☐ Lethargic

Orientation: ☑ Appropriate Response ☐ Inappropriate Response

Pupils: Brisk ☐ L ☐ R Sluggish ☐ L ☐ R Nonreactive ☐ L ☐ R

Size: L:____ R:____

Visual Acuity: ☑ N/A OD:____ OS:____

Movement: ☐ Voluntary ☐ Involuntary

Hand Grasp:	L	R
Strong	☐	☐
Weak	☐	☐
Absent	☐	☐

Slurred Speech? ☐ Yes ☐ No

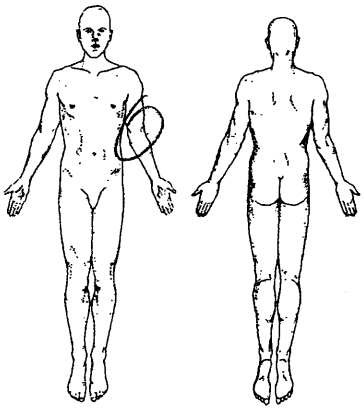
Abdominal

☐ Distended ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ LBM:____

Bowel Sounds: ☑ Present ☐ Absent

Comments:

Pain/Injury Location



Location (circled above)

Radiation (arrow above)

Laceration(s)

Location(s):

Size(s):

Bleeding Controlled: ☐ Yes ☐ No

Comments: N/A

Full Range of Motion ☐ Y ☐ N

Pulse:____ ☐ Y ☐ N

Sensation Intact: ☐ Y ☐ N

Emotional Assessment

Eye Contact ☑ Y ☐ N

Affect: ☑ Normal ☐ Flat ☑ Cooperative ☐ Disoriented ☐ Combative ☐ Anxious

Do you feel safe in your present living environment? ☑ Yes ☐ No

If no, would you like to talk to someone? ☐ Yes ☐ No

Comments:

GU-GYN

Pain in Voiding:	☐ Yes	☐ No
Frequency	☐ Yes	☑ No
Bleeding: N/A	☐ Yes	☐ No
Vaginal Bleeding	☐ Yes	☐ No
Vaginal Discharge	☐ Yes	☐ No

☐ Scant ☐ Moderate ☐ Large

Grav____ Para____ Ab____

Comments:

Orthopedic

Ext Deformity: ☐ Yes ☐ No

Full ROM: ☐ Yes ☐ No

Pulse:____

Cap. Refill: ☐ Brisk ☐ Slow

Temp: ☐ Warm ☐ Cold

Sensation Intact: ☐ Yes ☐ No

Pain Cont'd

Severity:

0 1 2 3 4 5 6 7 8 9 10

Exacerabated By:

Relieved By: ☑ Pt unable to rate

Nurse's Signature

TBradley RN

401A

Medications

Time	Medication	Rte	Site	Init	Response
1713	Rocephin 1gm	IM	(R) glut	TB	

IV Fluids

Time	Type of Fluid	Cath Size	Rate	Site	Initial

Pain Assessment/Reassessment

Pain Intensity: "Better"
0 1 2 3 4 5 6 7 8 9 10
❑Pt unable to rate
Time: 1735 Location: (L) arm
Intervention: ______
Initials: TB

Pain Intensity: ______
0 1 2 3 4 5 6 7 8 9 10
❑Pt unable to rate
Time: ______ Location: ______
Intervention: ______
Initials: ______

Pain Intensity: ______
0 1 2 3 4 5 6 7 8 9 10
❑Pt unable to rate
Time: ______
Location: ______
Intervention: ______
Initials: ______

Vital Signs

Time	Temp	Pulse	RR	B/P	SaO2
See continuation list TB					

Procedure/Treatment

Procedure/Treatment	Time	Ini
Cardiac Monitor		
O2 Type______ Rate:____		
EKG		
Xray Type:		
Location:		
Dressing Type:		
Location:		
Splint Type:		
Location:		
Foley:		
N/G Tube:		
Other:		

Nurses Notes

(1636) Amb to Bay 3 TB (1655) Dr Kraft in to Eval. Pt TB (1735) DC instructions given Written + Verbal TB

Notified: Time: 1645 Kraft
❑Police ❑Med. Examiner
❑Family/Friend ❑Health Dept.
❑Other (Whom: ______)
❑Valuables given to: ______
❑Sent Home

Intake: IV		Output: NG	
PO		Urine	
Other		Other	
Total		Total	

Nurse's Signature/Title	Init
Bradley Gym	TB
Pam Bain RN	PB

WIREGRASS MEDICAL CENTER

1200 W. MAPLE AVE.
GENEVA, AL 36340
(334) 684-3655

ED-OP
HOME INSTRUCTION SHEET

1. MEDICAL RECORD NO.	2. BILLING NO.	3. A/R NO.

INFORMATION

4. CLASS	5. DATE	6. TIME	7. SRC	8. TYPE	9. SAD

10. PATIENTS LEGAL NAME (L,F,MI)	11. SEX	12. RACE	13. BIRTHDATE	14. AGE	15. HEIGHT	16. WEIGHT	17. SS	18. MS	19.

20. RP	21. NOTIFY IN EMERGENCY	22. HOME TELE	23. WORK TELE	24. HOW PATIENT ARRIVED
N	E.R.			
513[illegible]88 KRAFT KURT D				

25. C COMPLAINT	26.		
D	08777 28 MALE		
06/04/05			

OUTPATIENT SURGERY INFORMATION

27. PROC CD	28. PROCEDURE	29. LOC	30. TIME	31. ANES

32. PHYSICIAN CALLED	33. ATTENDING PHYSICIAN	34. FAMILY PHYSICIAN
ER/ROOM		

SPRAIN, FRACTURE, & SEVERE BRUISES

- ☐ Elevate the injured part above level of heart to lessen swelling. If pillows flatten, use chair cushions with pillows or blanket for comfort.
- ☐ Ice packs also help prevent swelling, especially during the first 48 hours.
- ☐ Place ice in plastic or rubber bag, cloth covering; after 48 hours, use heat.
- ☐ If you have an elastic bandage, rewrap it if too tight or loose. Remove at bedtime and replace in A.M.
- ☐ If you have a cast, keep it perfectly dry at all times.
- ☐ Wiggle toes or fingers to help prevent swelling in the cast–this should be done often if it does not cause pain.
- ☐ If the part swells anyway or gets cold, blue or numb or pain increases markedly, have it checked promptly.
- ☐ Use crutches.

BACK AND NECK INJURY INSTRUCTIONS

- ☐ USE HEAT OR COLD ON THE INJURED AREA - whichever seems to help the most. Be careful not to burn yourself.
- ☐ Rest as much as possible until you are improved.
- ☐ Avoid positions and movement that make the pain worse.
- ☐ Relax emotionally - if you are tense the problem will on be worse.
- ☐ Gentle but firm massage will increase circulation in sore muscles and helps to clear the soreness.
- ☐ Wear special collar when out of bed.

HEAD INJURY INSTRUCTIONS

Persons who receive blows to the head may have injuries that cannot always be seen by X-ray or examination soon after accident. For the next 24 hours it is important that these instructions be followed:

- ☐ Awaken the patient every two hours, even at night, to be sure he knows where he is and is not confused.
- ☐ Check eyes to see that both pupils are of equal size.
- ☐ Prevent the taking of sleeping pills, tranquilizers or alcohol.
- ☐ Restrict excessive work or play.

Call your family doctor or local hospital immediately if the patient:

- ☐ Develops a severe headache.
- ☐ Vomits more than twice within a short time.
- ☐ Is confused, faints or is hard to awaken.
- ☐ Has a pupil of one eye larger that the other
- ☐ Complains of double vision
- ☐ Shows abnormal behavior such as staggering or walking into things.

X-RAY INSTRUCTIONS

Your X-rays have been read by the attending physician in the Emergency Dept. For your added protection, your X-rays will be reread the next morning by Radiology Dept. If any abnormalities are found that have not been called to your attention, you and your doctor will be called immediately. (Please be certain that the Emergency Dept. has a phone number where you can be reached.) Sometimes fractures or abnormalities may not show up on X-rays for several days. If your symptoms continue or get worse, call your doctor. More X-rays may need to be taken. If you are referred to another physician, come by the hospital and pick up your X-ray and take them with you to the doctor's office. Please call ahead to X-ray Dept.

WOUND CARE (Cuts, Abrasions, Burns, Stitches)

- ☐ Keep the dressings clean and dry.
- ☐ Elevate the wound to help relieve soreness and help speed wound healing.
- ☐ Despite the greatest care, any wound can be infected. If your wound becomes red, swollen, shows pus or red streaks, or feels more sore instead of less sore as days go by, you must report to your doctor right away.
- ☐ Dressing should be changed in _____ days.
- ☐ Treatment rendered _____.
- ☐ Tetanus Toxiod given _____. 250 units of tetanus immune globulin was given. To complete your immunization, you must receive two additional doses of toxoid 4-6 weeks apart. Call your physician for the next dose.
- ☐ Warm soaks to area 4 times daily. 20-40 minutes each time.
- ☐ Continuous warm compresses.

VOMITING & DIARRHEA

- ☐ Do not feed anything for 4 hours.
- ☐ After 4 hours, if there is not vomiting and/or diarrhea, offer 2 tablespoons (1 ounce) of any of the following: clear liquids, Coke, Gingerale, 7-up, weak tea, Gatorade or Jello, water. If patient is hungrey you may add 1 teaspoon of sugar to each ounce of liquid.
- ☐ UNDER NO CIRCUMSTANCES USE MILK OR MILK PRODUCTS.
- ☐ The 2 tablespoons of liquid may be offered every hour. If after 4 hours no vomiting has occured, the amount may be slowly increased.
- ☐ Using no more than ½ glass (4 ounces) of liquid at a time continue this treatment for 24 hours.
- ☐ Contact your doctor's office for further instructions after 24 hours.

GENERAL INSTRUCTIONS

- ☐ Stay in bed/may go to bathroom.
- ☐ Use vaporizor.
- ☐ Drink large amounts of liquids.
- ☐ Take _____ aspirin every 4 hours..
- ☐ Avoid any use of injured part.
- ☐ Allow only limited use of the part.
- ☐ You need not necessarily limit activity.
- ☐ Fill Prescriptions given to you from Emergency Dept. and take as directed.
- ☐ No driving or any activity requiring mental alertness after receiving medication.

FEVER OVER 102

- ☐ Sponge with lukewarm water in the tub.
- ☐ If temperature increases or persists for 24 hours, see your family doctor.

EYE INJURY

- ☐ Any eye injury is potentially hazardous.
- ☐ Any increasingly severe discomfort, redness or sudden impairment of vision should be reported immediately to your physician or eye specialist below.
- ☐ Do not drive with eye patch.

ANIMAL OBSERVATION

Instructions for observation of any animal that may have bitten a human if that animal is available for observation.

- ☐ Have animal taken to Vetennarian for observation.
- ☐ If the owner should refuse to take the animal to the Vetennarian, notify the County Health Officer of the situation.

contact family Physician as needed

ADDITIONAL INSTRUCTIONS Wound care — observe for any other signs of infection Return to ER as needed.

I hereby acknowledge receipt of all the instructions indicated above. I understand that I have received EMERGENCY treatment only and that I may be released before al my medical problems are known or treated. I will arrange for follow-up care as indicated above. I understand that if my conditions worsen or new symptoms appear, I should contact my Doctor immediately.

PATIENT/PARENT'S SIGNATURE	NURSE'S SIGNATURE	PHYSICIAN'S SIGNATURE	DATE
Jowell S.	Bradley Lynn		06/04/05

SCHOOL AND WORK EXCUSE *PATIENT NAME*

- ☐ No work for _____ days
- ☐ Light work for _____ days
- ☐ May return to work on _____
- ☐ No school for _____ days
- ☐ No Physical Education for _____ days
- ☐ May return to school on _____

WIREGRASS MEDICAL CENTER PHYSICIAN'S SIGNATURE

ADVANCE DIRECTIVE

ACKNOWLEDGEMENT

NAME: Nunn Jewel SOC. SEC. NO: 422-84-7896

IDENTIFICATION NO: 513688 DATE OF BIRTH: 01-08-1977

PLEASE READ THE FOLLOWING FOUR STATEMENTS.

1. I have been given written materials about my right to accept or refuse medical treatments

2. I have been informed of my rights to formulate Advance Directives.

3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility.

4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

☐ **I HAVE** executed an Advance Directive.

☒ **I HAVE NOT** executed an Advance Directive.

Signed X Jewel S. Nunn Date: 6-4-05

Witness: _____ Date: _____

Witness: Jasmine Spann Date: _____

Form # 390 Advance Directive Acknowledgement

NUNN JOMEL E.R.
DISCH KRAFT KURT D
DOB-01/08/77 28 MALE
06/04/05

ER/ROOM

Wiregrass Medical Center
ER Level of Service Charge Sheet

		Circulatory
		Jugular,Cutdown, Central Line
	19636430	Blood Administration
	19692960	Cardioversion, Mechanical
	19692950	Code Blue
	19692953	External Pacemaking
	19631500	Intubation
	19690471	Vacine Admin. (other than Rabies)
	19690675	Vacine Administration (Rabies)
	19690784	Medication Administration IV
X	19690782	Medication Administration IM or SQ
	19690780	IV infusion-up to 1 hour
	19690781	IV infusion-each additional hour
	19649080	Paracentesis
		Peritoneal Lavage/Tap
	19632000	Thoracentesis
	19633010	Pericardiocentesis
	19632002	Chest Tube Insertion
		IV Hydration
		ENT
		Eye Irrigation
		Eye Exam/Corneal Abrasion
		Foreign Body Removal Ear
		Foreign Body Removal Nose
		Irrigation Ear
		Nose Bleed/Nasal Packing
		Rust Ring (Foreign Body Removal)
		Respiratory
	19631603	Tracheotomy
	19631605	Cricothyrotomy
	19631603	Trach Change
		Gastrointestinal
	19691105	Gastric Lavage or NGT insertion
	19643760	Gastrostomy Tube Placement
		Genitourinary
	19659409	Delivery/Birth
		Supra Pubic Cath, or Turkey Tray
	19651700	Irrigation of Catheter
		Pelvic Exam

		Integumentary
	19611760	Repair of Nail Bed
	19611740	Subungal Hematoma
		Dressing Application
	19610120	FB removal
	19620000	I&D Abcess
	19600000	Laceration Repair (simple,intermed)
	19610000	Laceration Complex
	19611040	Debridement
	19616020	Treatment of Burns
		Orthopedics
		Behr Block/Regional Block
	19629500	Casting/Splinting
	19629705	Removal or Revision of Cast
		Tx of fx/dislocation with manipulation
	19620950	Compartmental Syndrome
		Neurological
	19662290	Lumbar Puncture
		Other
	19682962	Glucose fingerstick
		Treatment Level
	19699211	Low Level E/R
	19699281	Emergency WD
	19699282	Emergency I
		Emergency I with procedure
X	19699283	Emergency II
		Emergency II with procedure
	19699284	Emergency III
		Emergency III with procedure
	19699285	Emergency IV
		Emergency IV with procedure
	19699291	Critical Care
		Critical Care with procedure
		Observation I
		Observation II
		Observation III

NUNN JOMEL E.R.
513668 KRAFT KURT D
DOB-01/06/77 28 MALE
06/04/05

ER/ROOM

Wiregrass Medical Center
Emergency Physician's Charge Sheet

Date:_____

		Level of Service
	19599281	Level I
X	19599282	Level II
	19599283	Level III
	19599284	Level IV
	19599285	Level V
	19599288	Direct Life Support In Transit
	19599025	Visit with Surgery
	19599291	Critical Care per Hour
	19599292	Critical Care per 1/2 hour
	19591105	NG Lavage/Aspiration
	19599175	Ipecac Admin/Observe Gastric emptying

		Airway/Pulmonary
	19531500	Endotracheal Intubation
	19531511	FB Removal
	19532020	Tube Thoracostomy

		Vascular Procedures
	19536410	Non-Routine Venipuncture
	19590780	IV Therapy Requiring MD per hour
	19592977	Thrombolysis IV infusion

		Cardiac Procedures
	19592950	CPR
	19592953	Transcutaneous Pacing
	19592960	Cardioversion, Elective
	19593010	EKG Interpretation

		Ophthalmology
	19565205	FB
	19565210	FB Conjunctival/Embedded
	19567938	FB, Eyelid

		Ear,Nose, and Throat
	19542809	FB Pharynx
	19569200	FB External Ear Canal
	19569210	Impacted Cerumen
	19530300	FB Intranasal
	19530901	Anterior Epitaxis, Simple
	19530903	Anterior Epitaxis, Complex
	19530905	Posterior Epitaxis, Initial

		Soft Tissue/Foreign Body Removal
	19510120	Sub Q, Simple
	19510121	Sub Q, Complicated
	19520520	Muscle, Simple
	19520525	Muscle, Complex

		Nails
	19511730	Avulsion/Nail, Simple
	19512740	Subungal Hematoma

		Debridement
	19511000	Infected Skin
	19511040	Partial Skin Thickness
	19511041	Skin, Full Thickness
	19511042	Skin and Sub Q Tissue
	19511043	Skin, Sub Q, Muscle
	19511044	Skin, Sub Q, Muscle, Bone

		Hematoma and Abcess
	19510060	I&D Simple Abcess, Furuncle
	19510061	I&D Simple Abcess, Complicated/ Multiple
	19510140	I&D Hematoma Simple
	19510160	I&D Puncture Aspiration, Abcess
	19546320	Hemorrhoid, Thrombosed

		Burns
	19516000	First Degree Burn, Initial
	19516020	Small Burn, Debride,Dress
	19516025	Medium Burn, Debride/Dress
	19516030	Large Burn, Debride/Dress

		OB/GYN Procedures
	19556405	I&D, Abcess, Vulva
	19556420	I&D, Bartholin Abcess
	19559410	Emergency Vaginal Delivery

		Arthrocentesis
	19520600	Arthrocentesis, Small Joint
	19520605	Arthrocentesis, Intermediate Joint
	19520610	Arthrocentesis, Major Joint

		Miscellaneous Fractures
	19521800	Closed Rib Fracture
	19523500	Clavicle
	19523720	Closed Phalangeal Shaft
	19526750	Closed Distal Phalangeal
	19528490	Closed Fracture, Great Toe
	19528510	Closed Phalanx other than Gr. Toe

		Miscellaneous Closed Dislocations
	19521480	TMJ Uncomplicated
	19523650	Shoulder w/ Manipulation
	19524640	Nursemaid's Elbow
	19526700	Finger, MP Joint
	19526770	Finger, IP Joint
	19528660	Toe IP Joint

		Miscellaneous Procedures
	19553670	Urine Catheterization, Simple
	19553675	Urine Catheterization, Complex
	19562270	Spinal Puncture
	19564450	Digital Block
	19582270	Stool for Occult Blood
	19593042	Rhythm Strip Interpretation

		Repair/Simple- Single Layer
Scalp, Neck, Axillae, External Genitalia, Trunk, and/or extremities		
	19512001	2.5 cm or less
	19512002	2.6 - 7.5 cm
	19512004	7.6 - 12.5 cm
	19512005	12.6 - 20.0 cm
	19512006	20.1 - 30.0 cm
	19512007	Over 30.0 cm

		Repair/Simple- Single Layer Cont'd
Face, Ears, Eyelids, Nose, Lips, and/or Mucous Membranes		
	19512011	2.5 cm or less
	19512013	2.6 - 5.0 cm
	19512014	5.1-7.5 cm
	19512015	7.6 - 12.5 cm
	19512016	12.6 - 20.0 cm
	19512017	20.1 - 30.0 cm
	19512018	Over 30.0 cm
	19512020	Superficial WD Dehis
	19512021	Superficial WD Dehis-Pack

		Repair/Intermediate-Layered
Scalp, Axillae, Trunk, and/or Extremities		
	19512031	2.5 cm or less
	19512032	2.6 - 7.5 cm
	19512034	7.6 - 12.5 cm
	19512035	12.6 - 20.0 cm
	19512036	20.1 - 30.0 cm
	19512037	Over 30.0 cm
Neck, Hand, Feet, and/or External Genitalia		
	19512041	2.5 cm or less
	19512042	2.6 - 7.5 cm
	19512044	7.6- 12.5 cm
	19512045	12.6 - 20.0 cm
	19512046	20.0 - 30.0 cm
	19512047	Over 30.0 cm
Face, Ears, Eyelids, Nose, Lips, and/or Mucous Membranes		
	19512051	2.5 cm or less
	19512052	2.6 - 5.0 cm
	19512053	5.1 - 7.5 cm
	19512054	7.6 - 12.5 cm
	19512055	12.6 - 20.0 cm
	19512056	20.1 - 30.0 cm
	19512057	Over 30.0 cm

		Repair/Complex-Reconstructive or Complicated Wound Closure
Trunk		
	19513100	1.1 - 2.5 cm
	19513101	2.6 - 7.5 cm
Scalp, Arms, and/or Legs		
	19513120	1.1 - 2.5 cm
	19513121	2.6 - 7.5 cm
Forehead, Cheeks, Chin, Mouth, Neck, Axillae, Genitalia, Hands, and or Feet		
	19513132	1.1 - 7.5 cm
Eyelids, Nose, Ears, and/or Lips		
	19513151	1.1 - 2.5 cm
	19513152	2.6 - 7.5 cm

WIREGRASS MEDICAL CENTER 1200 W MAPLE AVE GENEVA AL 36340

EMERGENCY ROOM • OUTPATIENT RECORD

PATIENT NUMBER	TYPE	PATIENT NAME	AGE	BIRTHDATE	SEX	M/S	DATE OF SERVICE	TIME	CLERK INIT.
513811	3	NUNN JOWEL	28	1/08/1977	M	SB	6/06/05	13:09	ARB

ADDRESS - LINE 1	ADDRESS - LINE 2	CITY	STATE	ZIP CODE	TELEPHONE
202 SOUTH BROAD ST		SAMSON	AL	36477	334-898-9907

PATIENT SSAN	NOTIFY IN CASE OF EMERGENCY - NAME	RELATIONSHIP	ADDRESS	TELEPHONE
422847896	NUNN LINDA FAYE	MOTHER	SAME SAMSON AL	334-898-9907

INSURANCE COMPANY	CONTRACT OR GROUP NUMBER	DATE	PLACE	ACCIDENT
		TIME	EVENT	

GUARANTOR NAME	GUARANTOR ADDRESS	CITY	STATE	ZIP CODE	GUAR. TELEPHONE	GUARANTOR
NUNN JOWEL	202 SOUTH BROAD ST	SAMSON	AL	36477	898-9907	

GUARANTOR EMPLOYER	GUARANTOR OCCUPATION	GUAR. EMPLOYER ADDRESS	GUAR. EMPL TELEPHONE
SELF		COUNTY JAIL	

PREV. SERVICE	PREV. SERV. DATE	IF MINOR - PARENT NAME	MED. REC. #	ADMITTING/2ND PHYSICIAN
513688	6/04/05		422847896	MCLEOD J W/MITCHUM O

CHARGES	X-RAY	LAB	RESP. TH.	PHY. TH.	EKG	I.V.	DRUGS	SUPPLIES	OTHER	M.D.	E.R. RM	TOTAL DUE

AUTHORIZATION FOR TREATMENT, GUARANTEE OF PAYMENT , ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned has been informed of the emergency treatment considered necessary for the above named patient, and that treatment and procedures will be performed by physicians, members of house staff and employees of the hospital. Authorization is hereby granted for such treatment and procedures. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained.
2. The undersigned agrees to pay for services rendered by Hospital upon release of patient.
3. I/we hereby assign any hospital benefits, sick benefits, injury benefits due to a liability of a Third party, payable by any party, for the above patient, to Hospital unless I pay the account in full upon release of patient.
4. I/we hereby authorize the "Administrator of Hospital" to furnish from its records any information requested by the before mentioned insurance companies in connection with the above assignment. I do hereby appoint the "Controller" of Hospital as my lawful attorney to endorse for me any checks made payable to me for benefits or claims collected under the above assignment and to apply any credit balance to any other account I may owe said hospital.

DATE TIME SIGNED PATIENT SIGNED GUARANTOR

CHIEF COMPLAINT (If Accident State How, When, and Where)

TEMP.	PULSE	RESP.	B/P	ALLERGIES	MEDICATIONS - HOME	E.R. PHYSICIAN	TET. TOX.

NURSES NOTES:

NURSE'S SIGNATURE (RN OR LPN)

LAB DATA (Including X-Rays, EKGs, etc.)

PHYSICIAN'S REPORT

DIAGNOSIS:

TREATMENT:

CONDITION ON DISC: IMP | STABLE | EXPIRED

INSTRUCTIONS TO PATIENT:

FOLLOW-UP WITH

M.D.

PATIENT'S SIGNATURE ON DISCHARGE
BY SIGNING HERE I CERTIFY THAT I UNDERSTAND THE FOLLOW-UP INSTRUCTIONS RECEIVED BY ME IN WRITING, WHICH WERE EXPLAINED TO ME.

DATE - TIME OF DISC.

PHYSICIAN'S SIGNATURE

M.D.

NUNN JOWEL E.R.
513811 MCLEOD JIMMY W MD
DOB-01/08/77 28 MALE
06/06/05

F2/300

Wiregrass Medical Center
1200 W. Maple Avenue
Geneva, Alabama 36340

CONDITIONS FOR TREATMENT

1. **MEDICAL AND SURGICAL CONSENT FOR TREATMENT:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to furnish the necessary treatment, surgical procedures, anesthesia, x-ray examinations or treatments, drugs and supplies as may be ordered or requested by the attending physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery or examinations in the hospital. The undersigned recognizes that all physicians furnishing services to the patient may be independent contractors and are not employees or agents of the Hospital.

2. **RELEASE OF INFORMATION:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to release to any insurers, their representatives or other third parties confidential information (including copies of records) relative to this hospitalization. This authorization includes, but is not limited, to the release of information relating to drug, alcohol and or psychiatric treatment as specified in Federal Regulation 42, CFR part 2. I further authorize any physician or institution that attended the patient previously to furnish medical records or information which may be requested by the Hospital or attending physicians.

3. **RELEASE FROM LIABILITY FOR VALUABLES:** I have been made aware the WIREGRASS MEDICAL CENTER provides facilities for the safe keeping of my valuables and therefore, I release the Hospital from any responsibility due to loss or damage of my clothing, money, jewelry, or other items of value that I might keep at my bedside, or that may be brought to me by my friends and relatives.

4. **GUARANTOR AGREEMENT:** The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.

5. **ASSIGNMENT OF INSURANCE BENEFITS:** In the event the undersigned and/or patient is entitled to Hospital benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to WIREGRASS MEDICAL CENTER for application to the patient's bill. It is agreed that the Hospital may receipt for any such payment and such payment will discharge the said insurance company of all obligations under the policy to the extent of such payment. The undersigned and/or patient agrees to be responsible for charges not paid by this assignment.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ OR HAD THE FOREGOING INFORMATION EXPLAINED, HAS RECEIVED A COPY, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Date 6-6 20 05 X Jowel S. Nunn
Patient

Witness Ashley Hughes

Patient's Agent or Representative

Relationship to Patient

ASSIGNMENT OF MEDICARE BENEFITS:
PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST

"I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for Part A deductible for each spell of illness, the Part B deductible for each year, the remaining 20% of reasonable charges and any personal charges incurred."

Date | Signature | Relationship to Patient

ACKNOWLEDGEMENT OF MEDICARE

I hereby declare I am a participant in the Medicare Program and I am not enrolled in a health maintenance organization, (H.M.O.), or any other pre-paid group practice. I understand that if it is found that I am a participant in any of the above mentioned practices, I will be considered a self-pay patient required to pay in full immediately.

Date | Signature | Relationship to Patient

WIREGRASS MEDICAL CENTER

Billing Form

For Financial Class:

P

Patient Name..... NUNN, JOWEL
Admission Date..... 06/06/2005
Medical Record Number..... 422847896
Age..... 28
Account Number..... 513811

Discharge Date..... 06/06/2005
Date of Birth..... 01/08/1977
Sex..... Male

DX	Code	DX Description
1	707.8	Chronic Ulcer of Skin Site NEC
2	041.11	Staph Aureus Infect Site NOS/Dis Class Elsewhere
3	V09.0	Penicillin-Resistant Microorganism Infection

PR	Code	PR Description	Procedure Date	Surgeon

CPT	Code	CPT Modifiers	CPT Description	CPT Date	CPT Surgeon
		APC PSI	Payment Rate	ASC Group	ASC Fee

Attending Physician..... 006900
Consulting Physician.....
Discharge Disposition..... 01 - Home
DRG =
Status.....

Memo
DRG

MDC Weight AMLOS GMLOS LOS

NUNN JOVEL E.R.
513811 MCLEOD JIMMY W MD
DOB-01/08/77 28 MALE
06/06/05

ER/ROOM

(5)

& Joel Nunn 1-8-77

Wiregrass Medical Center
ER Medical Record

Addressograph ( ) Emergent ( ) Urgent (✓) Non-Emergent

Triage Notes: c/o wound (R) upper arm - sts started off as knot - now open draining wound - seen in Ga saturday - sts swabbed wound - started on antibotic	Time: 1320
	Temp: 995
Tet: Wt:	Pulse: 92
Allergies: NKDA LMP: SpO2:	Resp: 20
Meds: Bactrim -	BP: 156/104
Nurse Signature: L Hughes RN	
H&P and CC: Arm abscess	PMH:
HPI: 28 y/o male c infected ulcer on left arm - seen here 6/4 & started on Bactrim - first dose just few hours ago - says his arm is no better	Surg: Hernia
	Social/Habits: Tobacco / ETOH
General: WD WN -	Family Hx: noncontributed
HEENT	
Neuro:	ROS (Neg) Document if positive
Heart:	Neuro/Psych: ☐
Lungs:	Cardio/Resp: ☐
Musculoskeletal: 8-9 mm ulcer distal (L) arm	GU: ☐
Abd/Rectal: c swelling & redness	Other: ☐
GU/Gyn:	
Ext/Skin:	
Dx: Infected ulcer Suspect CA-MRSA	

Physician's Orders:	CBC( )	BMP/CMP		Medication	Ini
EKG( )	ABG( )	PT/PTT( )			
UA(Rout)(Cath)	CT( )	Amylase( )			
CXR( )	Other Studies	US( )			
CM( )	O2( )	Foley( )	IV:		

Disposition: Home(✓) Dr. Office( ) Surgery( ) Expired( ) Adm Rm# AMA/LWBS( ) Date/Time: 6-6-05 1410

Transfer to C/O Dr. Via

Condition at Discharge/Transfer: Improved( ) Stable(✓) Deteriorated( ) Unchanged(✓)

Instructions to Pt: (1) Rx: Bactrim & Keflex out BID

(2) Instructions: Local care

(3) Follow up: Recheck in 3-4 days

Signing this form denotes that I have reviewed all information on this document and I agree:

Physician's Signature: [signature] **Family Dr.** Mitchum

NUNN JOWEL E.R.
513811 MCLEOD JIMMY W MD
DOB-01/08/77 28 MALE
06/06/05

ER/ROOM

Addressograph

Wiregrass Medical Center
Emergency Department
Nursing Assessment

Mode of Arrival: ☑ Ambulatory ☐ Stretcher ☐ Ambulance ☐ Arms ☐ Other:_____

Accompanied By: ☐ Self ☐ Family/Friend ☑ Police ☐ Other
Immunizations up to date? ☐ Y ☐ N

Developmental Age Same as Stated Age ☐ Yes ☐ No

How do you prefer to learn? Written ☐ Verbal ☐ Combination ☑

Initial Contact Time: 1320 Allergies: NKDA
Date: 6-6-05

Treatment/RTA

None ☑ Cervical Collar ☐ Spineboard: ☐ Splint ☐ Dressings ☐ _____
IV Fluids:_____ Rate:_____ Site:_____
Airway: None ☐ Oral ☐ ET Tube ☐ ☐ Oxygen _____ via ☐ NC ☐ Mask

Nutritional Assessment

Are you on a regular diet? ☑ Y ☐ N
Have you had a recent weight loss or gain? ☐ Y ☑ N
Comments:_____

Respiratory

Respirations: ☑ Regular ☐ Irregular ☐ Shallow ☐ Deep
Breath Sounds: ☐ Bil. Clear ☐ Rhonchi ☐ Rales ☐ Wheezes
Cough: ☐ Productive ☐ Nonproductive
Sternal Retractions? ☐ Yes ☑ No
Dyspnea? ☐ Yes ☑ No
Comments:_____

Circulation

Skin: ☑ Warm ☑ Dry ☐ Hot ☐ Diaphoretic ☐ Cold ☐ Clammy
Color: ☑ Normal ☐ Pink ☐ Dusky ☐ Flushed ☐ Pale ☐ Cyanotic ☐ Jaundice
Edema: ☐ Yes ☑ No
JVD: ☐ Yes ☑ No
Capillary Refill: ☑ Quick ☐ Slow
Comments:_____

Glasgow Coma Scale

Eyes Open:	Spontaneously	4
	To Verbal Command	3
	To Pain	2
	No Response	1
Best Motor Response	Obeys	6
	Localizes Pain	5
	Flexion-Withdrawal	4
	Flexion/Abnormal (Decorticate Rigidity)	3
	Extension (Decerebrate Rigidity)	2
	No Response	1
Best Verbal Response	Oriented/Converses	5
	Disoriented/Converses	4
	Inappropriate Words	3
	Incomprehensible Sounds	2
	No Response	1

GCS Total (3-15):

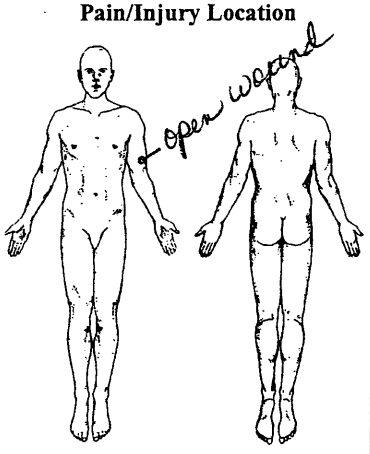
Neurological

Level of Consciousness: ☑ Alert ☐ Responds to Voice ☐ Responds to Pain ☐ Unresponsive ☐ Lethargic
Orientation: ☑ Appropriate Response ☐ Inappropriate Response
Pupils: Brisk ☐ L ☐ R Sluggish ☐ L ☐ R Nonreactive ☐ L ☐ R
Size: L:_____ R:_____
Visual Acuity: ☐ N/A OD:_____ OS:_____
Movement: ☐ Voluntary ☐ Involuntary
Hand Grasp: L ☐ R ☐ Strong ☐ ☐ Weak ☐ ☐ Absent ☐ ☐
Slurred Speech? ☐ Yes ☐ No

Abdominal

☐ Distended ☐ Nausea
☐ Vomiting ☐ Diarrhea
☐ Constipation ☑ LBM:_____
Bowel Sounds: ☐ Present ☐ Absent
Comments:_____

Pain/Injury Location



Location (circled above)

Radiation (arrow above)

GU-GYN

Pain in Voiding: ☐ Yes ☐ No
Frequency ☐ Yes ☐ No
Bleeding: ☐ Yes ☐ No
Vaginal Bleeding ☐ Yes ☐ No
Vaginal Discharge ☐ Yes ☐ No
☐ Scant ☐ Moderate ☐ Large
Grav_____ Para_____ Ab_____
Comments:_____

Laceration (s)

Location(s):_____
Size(s):_____
Bleeding Controlled: ☐ Yes ☐ No
Comments:_____
Full Range of Motion ☐ Y ☐ N
Pulse:_____ ☐ Y ☐ N
Sensation Intact: ☐ Y ☐ N

Pain

Severity:_____
0 1 2 3 4 (5) 6 7 8 9 10
Exacerabated By:_____
Relieved By:_____ ☐ Pt unable to rate

Orthopedic

Ext Deformity: ☐ Yes ☐ No
Full ROM: ☐ Yes ☐ No
Pulse:_____
Cap. Refill: ☐ Brisk ☐ Slow
Temp: ☐ Warm ☐ Cold
Sensation Intact: ☐ Yes ☐ No

Emotional/Assessment

Eye Contact ☑ Y ☐ N
Affect: ☑ Normal ☐ Flat
☑ Cooperative ☐ Disoriented
☐ Combative ☐ Anxious

Do you feel safe in your present living environment?
☐ Yes ☐ No
If no, would you like to talk to someone? ☐ Yes ☐ No
Comments: Inmate Geneva Co Jail

Nurse Signature

LHughes RN

401A

Medications

Time	Medication	Rte	Site	Init	Response

IV Fluids

Time	Type of Fluid	Cath Size	Rate	Site	Initial

Pain Assessment/Reassessment

Pain Intensity: _____
0 1 2 3 4 (5) 6 7 8 9 10
☐Pt unable to rate
Time: 1410 Location: (L) upper arm wound
Intervention: Rx Cleocin - bactroban
_____ Initials: LH

Pain Intensity: _____
0 1 2 3 4 5 6 7 8 9 10
☐Pt unable to rate
Time: _____ Location: _____
Intervention: _____
_____ Initials: _____

Pain Intensity: _____
0 1 2 3 4 5 6 7 8 9 10
☐Pt unable to rate
Time: _____
Location: _____
Intervention: _____
_____ Initials: _____

Vital Signs

Time	Temp	Pulse	RR	B/P	SaO2

Procedure/Treatment	Time	Ini
Cardiac Monitor		
O2 Type_____ Rate:____		
EKG		
Xray Type:		
Location:		
Dressing Type:		
Location:		
Splint Type:		
Location:		
Foley:		
N/G Tube:		
Other:		

Nurses Notes

(1330) To lobby to wait for available bed - LH
(1340) To bay #1 - accompanied by officer Jeff Lowery - LH
(1350) Dr. McLeod into visit - LH (1410) ~~Disch home~~ LH i inst-
(1410) Disch back to jail i officer - Rx et disch instructions went over i pt et officer - verbalyd understanding - Rx given to ~~pt~~ LH officer - LH

Notified: Time: In Ca
☐Police ☐Med. Examiner
☐Family/Friend ☐Health Dept.
☐Other (Whom: McLeod)
☐Valuables given to: _____
☐Sent Home

Intake: IV		Output: NG	
PO		Urine	
Other		Other	
Total		Total	

Nurse's Signature/Title	Init
L Hughes RN	LH

ER/ROOM

51381 MCLEOD JIMMY W MD
DOB-01/08/77 28 MALE
06/06/05

WIREGRASS MEDICAL CENTER

1200 W. MAPLE AVE.
GENEVA, AL 36340
(334) 684-3655

ED-OP
HOME INSTRUCTION SHEET

1. MEDICAL RECORD NO.	2. BILLING NO.	3. A/R NO.

INFORMATION

4. CLASS	5. DATE	6. TIME	7. SRC	8. TYPE	9. SAD

10. PATIENTS LEGAL NAME (L,F,MI)	11. SEX	12. RACE	13. BIRTHDATE	14. AGE	15. HEIGHT	16. WEIGHT	17. SS	18. MS	19.
NUNN JOWEL E. 513811 MCLEOD JIMMY W MD	M								

20. RP	21. NOTIFY IN EMERGENCY	22. HOME TELE	23. WORK TELE	24. HOW PATIENT ARRIVED
DOB 10/08/77 28 MALE 06/26/05				

25. C COMPLAINT 26.
ED/ROOM

OUTPATIENT SURGERY INFORMATION

27. PROC CD	28. PROCEDURE	29. LOC	30. TIME	31. ANES

32. PHYSICIAN CALLED	33. ATTENDING PHYSICIAN	34. FAMILY PHYSICIAN

SPRAIN, FRACTURE, & SEVERE BRUISES

- ☐ Elevate the injured part above level of heart to lessen swelling. If pillows flatten, use chair cushions with pillows or blanket for comfort.
- ☐ Ice packs also help prevent swelling, especially during the first 48 hours.
- ☐ Place ice in plastic or rubber bag, cloth covering; after 48 hours, use heat.
- ☐ If you have an elastic bandage, rewrap it if too tight or loose. Remove at bedtime and replace in A.M.
- ☐ If you have a cast, keep it perfectly dry at all times.
- ☐ Wiggle toes or fingers to help prevent swelling in the cast–this should be done often if it does not cause pain.
- ☐ If the part swells anyway or gets cold, blue or numb or pain increases markedly, have it checked promptly.
- ☐ Use crutches.

BACK AND NECK INJURY INSTRUCTIONS

- ☐ USE HEAT OR COLD ON THE INJURED AREA - whichever seems to help the most. Be careful not to burn yourself.
- ☐ Rest as much as possible until you are improved.
- ☐ Avoid positions and movement that make the pain worse.
- ☐ Relax emotionally - if you are tense the problem will on be worse.
- ☐ Gentle but firm massage will increase circulation in sore muscles and helps to clear the soreness.
- ☐ Wear special collar when out of bed.

HEAD INJURY INSTRUCTIONS

Persons who receive blows to the head may have injuries that cannot always be seen by X-ray or examination soon after accident. For the next 24 hours it is important that these instructions be followed:

- ☐ Awaken the patient every two hours, even at night, to be sure he knows where he is and is not confused.
- ☐ Check eyes to see that both pupils are of equal size.
- ☐ Prevent the taking of sleeping pills, tranquilizers or alcohol.
- ☐ Restrict excessive work or play.

Call your family doctor or local hospital immediately if the patient:

- ☐ Develops a severe headache.
- ☐ Vomits more than twice within a short time.
- ☐ Is confused, faints or is hard to awaken.
- ☐ Has a pupil of one eye larger that the other
- ☐ Complains of double vision
- ☐ Shows abnormal behavior such as staggering or walking into things.

X-RAY INSTRUCTIONS

Your X-rays have been read by the attending physician in the Emergency Dept. For your added protection, your X-rays will be reread the next morning by Radiology Dept. If any abnormalities are found that have not been called to your attention, you and your doctor will be called immediately. (Please be certain that the Emergency Dept. has a phone number where you can be reached.) Sometimes fractures or abnormalities may not show up on X-rays for several days. If your symptoms continue or get worse, call your doctor. More X-rays may need to be taken. If you are referred to another physician, come by the hospital and pick up your X-ray and take them with you to the doctor's office. Please call ahead to X-ray Dept.

WOUND CARE (Cuts, Abrasions, Burns, Stitches)

- ☐ Keep the dressings clean and dry.
- ☐ Elevate the wound to help relieve soreness and help speed wound healing.
- ☐ Despite the greatest care, any wound can be infected. If your wound becomes red, swollen, shows pus or red streaks, or feels more sore instead of less sore as days go by, you must report to your doctor right away.
- ☐ Dressing should be changed in _____ days.
- ☐ Treatment rendered _____.
- ☐ Tetanus Toxiod given _____. 250 units of tetanus immune globulin was given. To complete your immunization, you must receive two additional doses of toxoid 4-6 weeks apart. Call your physician for the next dose.
- ☐ Warm soaks to area 4 times daily. 20-40 minutes each time.
- ☐ Continuous warm compresses.

VOMITING & DIARRHEA

- ☐ Do not feed anything for 4 hours.
- ☐ After 4 hours, if there is not vomiting and/or diarrhea, offer 2 tablespoons (1 ounce) of any of the following: clear liquids, Coke, Gingerale, 7-up, weak tea, Gatorade or Jello, water. If patient is hungrey you may add 1 teaspoon of sugar to each ounce of liquid.
- ☐ UNDER NO CIRCUMSTANCES USE MILK OR MILK PRODUCTS.
- ☐ The 2 tablespoons of liquid may be offered every hour. If after 4 hours no vomiting has occured, the amount may be slowly increased.
- ☐ Using no more than ½ glass (4 ounces) of liquid at a time continue this treatment for 24 hours.
- ☐ Contact your doctor's office for further instructions after 24 hours.

GENERAL INSTRUCTIONS

- ☐ Stay in bed/may go to bathroom.
- ☐ Use vaporizor.
- ☐ Drink large amounts of liquids.
- ☐ Take _____ aspirin every 4 hours..
- ☐ Avoid any use of injured part.
- ☐ Allow only limited use of the part.
- ☐ You need not necessarily limit activity.
- ☐ Fill Prescriptions given to you from Emergency Dept. and take as directed.
- ☐ No driving or any activity requiring mental alertness after receiving medication.

FEVER OVER 102

- ☐ Sponge with lukewarm water in the tub.
- ☐ If temperature increases or persists for 24 hours, see your family doctor.

EYE INJURY

- ☐ Any eye injury is potentially hazardous.
- ☐ Any increasingly severe discomfort, redness or sudden impairment of vision should be reported immediately to your physician or eye specialist below.
- ☐ Do not drive with eye patch.

ANIMAL OBSERVATION

Instructions for observation of any animal that may have bitten a human if that animal is available for observation.

- ☐ Have animal taken to Vetennarian for observation.
- ☐ If the owner should refuse to take the animal to the Vetennarian, notify the County Health Officer of the situation.

ADDITIONAL INSTRUCTIONS add Bacfroban Oint to wound care - wash wound with warm soapy water - dry - apply oint twice a day and cover wound - See Dr. Mitchum in office for wound check 3-4 days

I hereby acknowledge receipt of all the instructions indicated above. I understand that I have received EMERGENCY treatment only and that I may be released before al my medical problems are known or treated. I will arrange for follow-up care as indicated above. I understand that if my conditions worsen or new symptoms appear, I should contact my Doctor immediately.

PATIENT/PARENT'S SIGNATURE: x Jowel Nunn

NURSE'S SIGNATURE: L Hughes, RN

PHYSICIAN'S SIGNATURE:

SCHOOL AND WORK EXCUSE

PATIENT NAME *DATE*

- ☐ No work for _____ days
- ☐ Light work for _____ days
- ☐ May return to work on _____
- ☐ No school for _____ days
- ☐ No Physical Education for _____ days
- ☐ May return to school on _____

WIREGRASS MEDICAL CENTER PHYSICIAN'S SIGNATURE

ADVANCE DIRECTIVE
ACKNOWLEDGEMENT

NAME: Nunn, Jowel SOC. SEC. NO: 422847896
IDENTIFICATION NO: 5131 DATE OF BIRTH: 1-8-77

PLEASE READ THE FOLLOWING FOUR STATEMENTS.

1. I have been given written materials about my right to accept or refuse medical treatments

2. I have been informed of my rights to formulate Advance Directives.

3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility.

4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

☐ **I HAVE** executed an Advance Directive.

☒ **I HAVE NOT** executed an Advance Directive.

Signed Jowel S Nunn Date: 6-6-05

Witness:_____ Date:_____

Witness: Ashley Hughes Date: 6-6-05

Form # 390 Advance Directive Acknowledgement

NUNN JOWEL E.R.
513811 MCLEOD JIMMY W MD
DOB-01/08/77 28 MALE
06/06/05

ER/ROOM

Wiregrass Medical Center

Emergency Physician's Charge Sheet Date:

Level of Service	
19599281	Level I
19599282	Level II
19599283	Level III
19599284	Level IV
19599285	Level V
19599288	Direct Life Support In Transit
19599025	Visit with Surgery
19599291	Critical Care per Hour
19599292	Critical Care per 1/2 hour
19591105	NG Lavage/Aspiration
19599175	Ipecac Admin/Observe Gastric emptying

Airway/Pulmonary	
19531500	Endotracheal Intubation
19531511	FB Removal
19532020	Tube Thoracostomy

Vascular Procedures	
19536410	Non-Routine Venipuncture
19590780	IV Therapy Requiring MD per hour
19592977	Thrombolysis IV infusion

Cardiac Procedures	
19592950	CPR
19592953	Transcutaneous Pacing
19592960	Cardioversion, Elective
19593010	EKG Interpretation

Ophthalmology	
19565205	FB
19565210	FB Conjunctival/Embedded
19567938	FB, Eyelid

Ear, Nose, and Throat	
19542809	FB Pharynx
19569200	FB External Ear Canal
19569210	Impacted Cerumen
19530300	FB Intranasal
19530901	Anterior Epitaxis, Simple
19530903	Anterior Epitaxis, Complex
19530905	Posterior Epitaxis, Initial

Soft Tissue/Foreign Body Removal	
19510120	Sub Q, Simple
19510121	Sub Q, Complicated
19520520	Muscle, Simple
19520525	Muscle, Complex

Nails	
19511730	Avulsion/Nail, Simple
19512740	Subungal Hematoma

Debridement	
19511000	Infected Skin
19511040	Partial Skin Thickness
19511041	Skin, Full Thickness
19511042	Skin and Sub Q Tissue
19511043	Skin, Sub Q, Muscle
19511044	Skin, Sub Q, Muscle, Bone

Hematoma and Abcess	
19510060	I&D Simple Abcess, Furuncle
19510061	I&D Simple Abcess, Complicated/ Multiple
19510140	I&D Hematoma Simple
19510160	I&D Puncture Aspiration, Abcess
19546320	Hemorrhoid, Thrombosed

Burns	
19516000	First Degree Burn, Initial
19516020	Small Burn, Debride,Dress
19516025	Medium Burn, Debride/Dress
19516030	Large Burn, Debride/Dress

OB/GYN Procedures	
19556405	I&D, Abcess, Vulva
19556420	I&D, Bartholin Abcess
19559410	Emergency Vaginal Delivery

Arthrocentesis	
19520600	Arthrocentesis, Small Joint
19520605	Arthrocentesis, Intermediate Joint
19520610	Arthrocentesis, Major Joint

Miscellaneous Fractures	
19521800	Closed Rib Fracture
19523500	Clavicle
19523720	Closed Phalangeal Shaft
19526750	Closed Distal Phalangeal
19528490	Closed Fracture, Great Toe
19528510	Closed Phalanx other than Gr. Toe

Miscellaneous Closed Dislocations	
19521480	TMJ Uncomplicated
19523650	Shoulder w/ Manipulation
19524640	Nursemaid's Elbow
19526700	Finger, MP Joint
19526770	Finger, IP Joint
19528660	Toe IP Joint

Miscellaneous Procedures	
19553670	Urine Catheterization, Simple
19553675	Urine Catheterization, Complex
19562270	Spinal Puncture
19564450	Digital Block
19582270	Stool for Occult Blood
19593042	Rhythm Strip Interpretation

Repair/Simple-Single Layer	
Scalp, Neck, Axillae, External Genitalia, Trunk, and/or extremities	
19512001	2.5 cm or less
19512002	2.6 - 7.5 cm
19512004	7.6 - 12.5 cm
19512005	12.6 - 20.0 cm
19512006	20.1 - 30.0 cm
19512007	Over 30.0 cm

Repair/Simple-Single Layer Cont'd	
Face, Ears, Eyelids, Nose, Lips, and/or Mucous Membranes	
19512011	2.5 cm or less
19512013	2.6 - 5.0 cm
19512014	5.1-7.5 cm
19512015	7.6 - 12.5 cm
19512016	12.6 - 20.0 cm
19512017	20.1 - 30.0 cm
19512018	Over 30.0 cm
19512020	Superficial WD Dehis
19512021	Superficial WD Dehis-Pack

Repair/Intermediate-Layered	
Scalp, Axillae, Trunk, and/or Extremities	
19512031	2.5 cm or less
19512032	2.6 - 7.5 cm
19512034	7.6 - 12.5 cm
19512035	12.6 - 20.0 cm
19512036	20.1 - 30.0 cm
19512037	Over 30.0 cm
Neck, Hand, Feet, and/or External Genitalia	
19512041	2.5 cm or less
19512042	2.6 - 7.5 cm
19512044	7.6- 12.5 cm
19512045	12.6 - 20.0 cm
19512046	20.0 - 30.0 cm
19512047	Over 30.0 cm
Face, Ears, Eyelids, Nose, Lips, and/or Mucous Membranes	
19512051	2.5 cm or less
19512052	2.6 - 5.0 cm
19512053	5.1 - 7.5 cm
19512054	7.6 - 12.5 cm
19512055	12.6 - 20.0 cm
19512056	20.1 - 30.0 cm
19512057	Over 30.0 cm

Repair/Complex-Reconstructive or Complicated Wound Closure	
Trunk	
19513100	1.1 - 2.5 cm
19513101	2.6 - 7.5 cm
Scalp, Arms, and/or Legs	
19513120	1.1 - 2.5 cm
19513121	2.6 - 7.5 cm
Forehead, Cheeks, Chin, Mouth, Neck, Axillae, Genitalia, Hands, and or Feet	
19513132	1.1 - 7.5 cm
Eyelids, Nose, Ears, and/or Lips	
19513151	1.1 - 2.5 cm
19513152	2.6 - 7.5 cm

NUNN JOWEL E.R.
513811 MCLEOD JIMMY W MD
DOB-01/08/77 28 MALE
06/06/05

ER/ROOM

Wiregrass Medical Center
ER Level of Service Charge Sheet

		Circulatory
		Jugular,Cutdown, Central Line
	19636430	Blood Administration
	19692960	Cardioversion, Mechanical
	19692950	Code Blue
	19692953	External Pacemaking
	19631500	Intubation
	19690471	Vacine Admin. (other than Rabies)
	19690675	Vacine Administration (Rabies)
	19690784	Medication Administration IV
	19690782	Medication Administration IM or SQ
	19690780	IV infusion-up to 1 hour
	19690781	IV infusion-each additional hour
	19649080	Paracentesis
		Peritoneal Lavage/Tap
	19632000	Thoracentesis
	19633010	Pericardiocentesis
	19632002	Chest Tube Insertion
		IV Hydration
		ENT
		Eye Irrigation
		Eye Exam/Corneal Abrasion
		Foreign Body Removal Ear
		Foreign Body Removal Nose
		Irrigation Ear
		Nose Bleed/Nasal Packing
		Rust Ring (Foreign Body Removal)
		Respiratory
	19631603	Tracheotomy
	19631605	Cricothyrotomy
	19631603	Trach Change
		Gastrointestinal
	19691105	Gastric Lavage or NGT insertion
	19643760	Gastrostomy Tube Placement
		Genitourinary
	19659409	Delivery/Birth
		Supra Pubic Cath, or Turkey Tray
	19651700	Irrigation of Catheter
		Pelvic Exam

		Integumentary
	19611760	Repair of Nail Bed
	19611740	Subungal Hematoma
		Dressing Application
	19610120	FB removal
	19620000	I&D Abcess
	19600000	Laceration Repair (simple,intermed)
	19610000	Laceration Complex
	19611040	Debridement
	19616020	Treatment of Burns
		Orthopedics
		Behr Block/Regional Block
	19629500	Casting/Splinting
	19629705	Removal or Revision of Cast
		Tx of fx/dislocation with manipulation
	19620950	Compartmental Syndrome
		Neurological
	19662290	Lumbar Puncture
		Other
	19682962	Glucose fingerstick
		Treatment Level
	19699211	Low Level E/R
	19699281	Emergency WD
✓	19699282	Emergency I
		Emergency I with procedure
	19699283	Emergency II
		Emergency II with procedure
	19699284	Emergency III
		Emergency III with procedure
	19699285	Emergency IV
		Emergency IV with procedure
	19699291	Critical Care
		Critical Care with procedure
		Observation I
		Observation II
		Observation III